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ABSTRACT

These proceedings of the second annual symposium on population growth bring together speeches and panel discussions on family planning programs. Titles of speeches delivered are: Communicating Family Planning (Mrs. Jean Hutchinson); Effects of New York's Abortion Law Change (Dr. Walter Rogers); The Law and Birth Control, Sterilization and Abortion (Mrs. Harriet F. Pilpel); International Postpartum Program for Family Planning (Dr. Frank Shubeck); Consequences of Family Planning for Man's Genetic Future (Dr. James Crow); The Psychology of Family Size Desires (Dr. Edward Pohlman); and, Hospital Based Family Planning Services in an Urban Setting (Dr. Hugh Davis). The two panel discussions focus on a broad spectrum of related issues that were initiated by the audience. Among them are: insurance payments for voluntary sterilization; use of paramedical personnel in family planning services; religious, personal, and social attitudes which inhibit the adoption of family planning practices; legal issues; and promiscuity and venereal disease, etc. A list of books and articles on various aspects of family planning conclude the report. The proceedings of the first annual symposium are reported in SO 001 171. (JLB)

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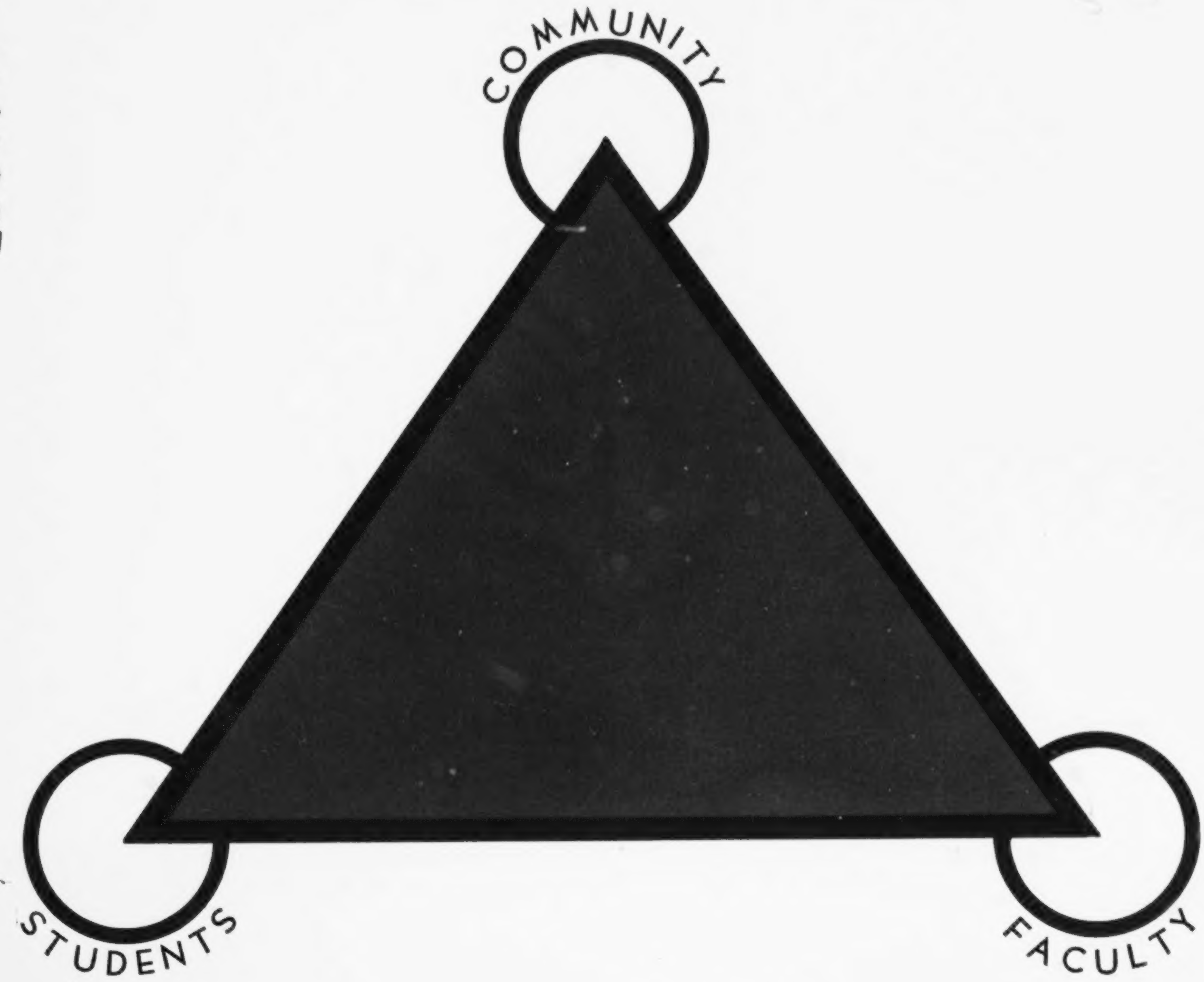
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Proceedings of the Second Annual Symposium

POPULATION GROWTH: FAMILY PLANNING PROGRAMS

January 8 and 9, 1971

COLLEGE OF HUMAN BIOLOGY
The University of Wisconsin - Green Bay

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Editors:
A.R. Doberenz
N.B.G. Taylor

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Population Growth: Family Planning Programs

8, 9 January 1971
Green Bay, Wisconsin

Sponsored by

COLLEGE OF HUMAN BIOLOGY

THE UNIVERSITY OF WISCONSIN - GREEN BAY

Alexander R. Doberenz
N. Burwell G. Taylor
Editors

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COVER

The green triangle on the cover of these Proceedings represents the "communiversity concept" of students, faculty and community working together to solve today's problems.

PROCEEDINGS

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On behalf of the members of the Symposium Committee we wish to express our sincerest thanks to many individuals.

Our warmest appreciation is extended to our invited speakers whose contributions constitute the major portion of these proceedings: Mrs. Jean K. Hutchinson, Dr. Walter Rogers, Mrs. Harriet F. Pilpel, Dr. Frank Shubeck, Dr. James F. Crow, Dr. Edward W. Pohlman and Dr. Hugh Davis.

Sincere thanks are also extended to Dr. John R. Beaton, Dr. Jeremy Green, Dr. Herbert Sandmire, Dr. Richard M. Fontera, Mr. John Van Miller and Mrs. Evelyn Farrell for the significant roles they played.

We extend special acknowledgments to Mrs. Joanna Berentson, Miss Joan Carpiaux, Miss Betty McDowell and Miss Julie Reisinger for their excellent assistance in the preparation and collation of these proceedings.

We wish to thank the Office of Community Outreach and Research and Dr. R. S. Cook, Academic Conference Coordinator, for their assistance in printing these proceedings.

Without the assistance and contributions of a great number of other persons, the Second Annual Population Symposium could not have become a reality.

PREFACE

The methodology of contraception has reached a high level of effectiveness: the advent of the intrauterine contraceptive device and of the oral hormonal contraceptive pill have made technically possible the control of the human population size, almost at will. Despite this, a decrease in the world population growth rate is not detectable and, with one or two notable exceptions, national birth control programs have failed to accomplish their planned objectives.

The key phrase in the above paragraph is "at will". What makes a nation or a people "will" to increase or decrease its numbers? It becomes more and more evident that the answer to this question is as important as knowledge of contraceptive methods if the numbers of human beings on this earth are to be regulated. The Second Symposium on Population Growth addresses itself to closely related questions. What are the needs for population regulation? Why should, and how can, contraceptive information be communicated to the individuals who made up the reproductive segment of a population, in order that they may decide when, or by what methods, they will alter their fertility?

These Proceedings include evaluation of family planning programs - the successes, the frustrations, the inadequacies and the prospects for the future.

A. R. Doberenz
N. B. G. Taylor

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NOTES ON THE SPEAKERS

Dr. James F. Crow received his Ph.D. degree in genetics from the University of Texas. He is currently Professor and Chairman of the Department of Genetics and Medical Genetics at The University of Wisconsin. Dr. Crow has written several books and over 75 articles, many of which were concerned with population genetics. He is a member of the National Academy of Science; American Philosophical Society; past president of the Genetic Society of America; past president of the American Society for Human Genetics; was chairman of the Genetic Study Section, National Institute of Health; and is a member of several other scientific organizations.

Dr. Hugh J. Davis holds the M.D. degree from Johns Hopkins University where he is now Director of the Family Planning Clinic, Assistant Professor of Gynecology and Obstetrics in the School of Medicine, and Assistant Professor of International Health and of Population Dynamics in the School of Hygiene and Public Health. He holds memberships in several scientific societies and is the author of numerous professional publications on family planning and related subjects.

Jean K. Hutchinson received the B.A. degree from Douglas College, Rutgers University. Since then she has been a social worker, a school teacher and a newspaper journalist. She won the New York State Press Award for feature writing in 1956. She is a member of the National Information and Education Advisory Committee of Planned Parenthood-World Population.

Harriet F. Pilpel received her B.A. degree from Vassar College, her M.A. in International Relations and Public Law from Columbia University, and an LL.D. from Columbia Law School. She is a member of the Board of Directors and counsel to Planned Parenthood-World Population; a member of the Council for the Population Planning Program; member of the Bar Association of the City of New York, the American Bar Association; vice chairman and member of the National Board of Directors of the American Civil Liberties Union; member of the Panel of Experts of U.S. Government Copyright Office; and consultant to the Special Committee on Divorce and Marriage Law of the National Conference of Commissioners on Uniform State Laws. Mrs. Pilpel is the author of numerous books and articles concerned with freedom of speech and press, birth control, abortion and related subjects. She writes a monthly column in Publisher's Weekly magazine.

Dr. Edward W. Pohlman received his Ph.D. degree in psychology from Ohio State University. He has been a visiting professor at the Central Family Planning Institute, New Delhi, and acting director of the New Delhi Office of the Pathfinder Fund. Dr. Pohlman has written three books and more than 50 technical articles relating to family planning and population; has recently completed a 13-week TV series for a commercial station dealing with abortion, contraception, sterilization, ecology and population; and has been a consultant for the World Health Organization (Geneva), and the National Institute of Child Health and Human Development, and the National Medical Association (both in Washington, D.C.). He is a member of the American Psychological Association's Task Force on Family Planning, Psychology and Population Policy.

Dr. Walter C. Rogers received the M.D. degree from the University of Rochester and took post-graduate training in obstetrics and gynecology and in pathology. After several years in private practice, Dr. Rogers served with Project Hope as Chief of Medical Staff aboard the S.S. Hope at the Republic of Guinea (West Africa), Nicaragua, Colombia and Ceylon. Among other national and international awards, he has received the Reuben Dario Medal from the government of Colombia and an Honorary Professorship from the University of Cartagena Medical School. Dr. Rogers is an active member of a number of scientific societies, including a Founding Fellow of the American College of Obstetricians and Gynecologists and Executive Secretary of the American Association of Planned Parenthood Physicians.

Dr. Frank Shubeck holds the M.D. degree from the University of Michigan and completed his internship and residence at the University Hospital. He is a member of several scientific societies including the American College of Obstetricians and Gynecologists and the American Fertility Society. Dr. Shubeck has had extensive overseas experience including service as the Regional Director, Far East, of the Technical Assistance Division for The Population Council. Currently he is serving as liaison for the Technical Assistance and Biomedical Divisions which are actively engaged in contraceptive research.

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SESSION ONE

Friday, 8 January, Morning
Beaumont Motor Inn

Session Chairman:

Dr. Alexander R. Doberenz
Assistant Dean
College of Human Biology
The University of Wisconsin - Green Bay

Speakers:

Dr. John R. Beaton
Mrs. Jean K. Hutchinson
Dr. Walter Rogers
Mrs. Harriet F. Pilpel

Introduction and Welcome

To our speakers, our panel members and to each of you present in our audience, I extend a sincere welcome on behalf of the College of Human Biology of The University of Wisconsin - Green Bay.

One year ago in January 1970, I had the pleasure of opening the first annual symposium on Population Growth: Crisis and Challenge. Response at that symposium and subsequently was excellent. There has been a new and renewed awareness of the problems - with particular reference to our problems in Northeastern Wisconsin.

Our first annual symposium considered population problems in a broad perspective, including such areas as the Asian situation, birth control, malnutrition, leisure, pollution, conservation of resources, and federal and foundation agencies. This served as a good base upon which to develop and build future symposia and conferences on a selective basis. Our second annual symposium is an example, dealing specifically with family planning programs.

Much has happened, although not enough, in the United States during the past year in relation to control of population growth. Laws have been changed and I am sure we will hear more of this aspect from Dr. Rogers and Mrs. Pilpel this morning. Family planning programs have gained new status and we will learn more of this during the symposium. In my own view, the major population growth problems facing us still are not those of technology, but rather those of communicating information and of assessing attitudes toward family size. I am looking forward to hearing the remarks of Mrs. Hutchinson, Dr. Davis, Dr. Shubeck and Dr. Pohlman in these areas.

When I opened last year's symposium, I quoted figures which indicate the very high rate of population growth in Northeastern Wisconsin - particularly in our Brown County. These calculations were based upon informed but necessarily incomplete data. As you all know, the 1970 census has been completed now and the results essentially support my estimates of last year. The rate of population growth in Brown County is well above the national average. Between 1960 and 1970, Brown County's propulation increased by twenty-seven percent for this ten-year period - a large increase indeed. Obviously, it would be erroneous to attribute all of this increase to a relatively high birth rate and large family size; certainly a decreased death rate and immigration are also contributing factors. However, to ignore a high birth rate and an apparent desire for large families would be a serious omission. I think we are all aware of the many problems developed upon a base of rapid and excessive population growth.

Two panel discussions are scheduled during this symposium; I would emphasize that we hope these will serve as an open forum. Questions and comments from the audience are not only welcomed, they are encouraged. There will be ample opportunity and all questions and answers will be recorded in the proceedings of this symposium.

In closing, I would again extend a welcome to each of you. This symposium represents one more example of the community and national involvement of The University of Wisconsin - Green Bay, a role which we accept most seriously. We appreciate your interest and we hope that this symposium will serve you in providing significant information and a focus on a most important problem area.

Communicating Family Planning

Jean K. Hutchinson

Public Relations Director
Planned Parenthood Center of Buffalo

Communicating family planning can be as grandiose as President Nixon's population and family planning message to Congress or as simple as telling your neighbor about birth control. It's a college student's button that says "Birth control takes the worry out of being close". It's a subway card in New York that reads, "If you are old enough to have children, you are old enough to decide when". In Taiwan a postage stamp promotes the two child family image and a pamphlet in Fiji bluntly states, "More than two children is bad for the country and you, too". The electric building in Milwaukee spells out in lights, "Support Planned Parenthood" and a forty foot display in the Buffalo Museum of Science compares a five generation projection of two child families with a five generation projection of four child families. The University of Wisconsin student press in Madison passed out thousands of birth control manuals last month and the establishment press carried news of the researching of the new prostaglandin drug that could revolutionize birth control. Joanne Woodward periodically appears on your TV set to tell you that overpopulation is everybody's problem. All this is communicating family planning. Even an elephant roams around India sporting the red triangle - symbol of family planning there.

Family planning communication on this scale is relatively new. It is only in the last few years that we have blossomed forth so prodigiously. It took us close to fifty years to become legal, respectable and acceptable enough to publicly promote and discuss birth control. This is not really very long for a social reform movement, particularly one so intimately involved with the most sensitive area of our lives - with procreation, human sexuality, the reproductive organs and with life itself. Communicators have had to deal with folklore handed down for generations, stubborn cultural hang-ups, endless misinformation and often just plain old gossip. They have had to develop a sensitivity to and understanding of the disapproval of Black Muslims, the John Birch Society and a new group that challenges our firm philosophy of freedom of choice and voluntaryism as a cop-out in lieu of the world situation. The subject easily gets mixed up with genocide, has always been a serious concern of religions, and recently has become a monumental political issue as well. In addition, the overpopulation crisis is currently at our backs pressuring us to get the job done quickly; to find new ways to make people understand that the world can no longer sustain us all and we are running out of time.

Sometimes we are handicapped by lack of scientifically based information that could help us to be more consistently effective. For example, we could use more studies on the psycho-socio reasons why people decide to have children or not to have them. We know more about what to expect of people in regard to planting wheat and buying TV sets than we do about their reproductive decisions.(1)

However, in spite of these complications, we are beginning to see results. The fertility rate in our country has decreased and the number of family planning patients increased. At one time Planned Parenthood assumed it would put itself out of business as soon as public health agencies could be persuaded to offer contraceptive services, but this has not been the case. As more and more public and private health facilities provide birth control care and show growing caseloads, Planned Parenthood patients continue to increase too. We are the fastest growing health agency in the country, and are adding new services in many affiliates: VD testing; teenage rap sessions and clinics; vasectomies; abortions, pregnancy testing and counseling; and the educational aspects of the service have mushroomed into sex education, population ecology education, resource libraries and school curriculum programs.

But the job is far from done. Eighty-five percent of the medically dependent women in their child bearing years in the United States still do not have access to family planning. Our quality of life and standard of living continues to diminish and population growth has not yet leveled off to the extent that it must. Unwanted births account for between one-third and one-half of the U.S. population growth. Archaic laws continue to hamper us and we still have to fight for acceptance in many areas of the country.

But the sturdy birth control movement is used to making steady progress, as the past fifty years show. Originally family planning was communicated by word of mouth and a few tiny books in plain wrappers, passed surreptitiously from hand to hand. Later information was issued only by authoritative professional sources - the doctor, minister or Planned Parenthood worker. The ticket to get it was, of course, a marriage certificate. It still is in Wisconsin. You have the distinction of being the last hold-out in the country.

(1) Fawcett, James T., 1970, Psychology and Population, Published by The Population Council, page 12.

The obvious people who should have been communicating family planning were not allowed to - public health, welfare and social workers. It wasn't taught in medical or nursing schools, so they didn't know much to communicate. Gradually as legal battles were won, acceptance grew. The press on rare occasions carried Planned Parenthood news. Generally, it was tucked away on the obituary page. More than likely it was a small notice that the socially acceptable ladies were having a luncheon to promote their fund raising drive. But, at least, the press began to admit that Planned Parenthood existed at all.

In 1960 the coming of the pill gave us a tremendous boost. This was a newsworthy, miraculous scientific discovery. It further had the good grace to be completely divorced from the sex act with no anatomical implications such as the condom and diaphragm, about which people still have difficulty talking. It was easy to talk about the pill, however, and caused no particular hysteria. The written word then found it could discuss the IUDs too - a method also divorced from the sex act.

TV was busily showing the gastro-intestinal tract, but not quite ready for birth control. Eventually some local stations were willing to run public service spots for fund raising and a very few ran a limited number of patient recruitment spots.

In the Spring of 1967, Planned Parenthood decided the time was ripe to launch an all-out across the country effort to recruit patients by using TV spots. It was sort of a gamble because no one had any real idea of how effective it would be or what message would have the greatest appeal. We were not at all sure what cooperation could be expected from TV stations or even what terms to use. Should we say "birth control" and risk being misinterpreted or offensive? Would anyone understand what family planning meant? The dilemna was nicely solved when Pope Paul came out with "Humanae Vita". He said "birth control" and overnight this became a universally understood and accepted term by both media and the public. Publications, TV and radio burst with birth control features. The publicity was marvelous and continues to this day. Between this and our new TV spots that were running at the same time, my agency in Buffalo was literally innundated with patients. We have not had to do any patient recruitment since. We simply could not handle such an influx of new patients again and barely manage our continued rapid growth rate now.

With the changed climate and widening opportunities, the whole wonderful world of communication has opened up to family planning. We have jumped into everything - not always wisely. I think it is healthy to look (and maybe even laugh) at our failures and goofs as well as our successes. It is one of the ways we learn our trade and avoid each others pitfalls.

We came up with a snappy rock tune once ("Ya Gotta Be Needed. You Gotta be Wanted"). I liked it but it never made the top ten. At one stage many of our best publications and almost all our stationary were adorned with pictures of absolutely irrestible babies to show that we were not anti-babies - as indeed we are not. They made some of us want to go home and have another one immediately. The uninformed must have wondered what we were promoting.

In our zealousness to push overpopulation awareness as well as family planning, we started one promotional campaign with the theme, "Love is the child not born". Those in the field understood what it meant and, correctly interpreted, it is quite right. Unfortunately it quickly got translated into, "And hate is the child that is born".

Sometimes we have used phrases out of context - phrases easily understood on a professional level, but not necessarily understood by the public. We are prone to say that planned families are happier, healthier families and the wanted child is a happy child. In context and in general terms this is undeniably true. It would be helpful if everyone understood it. People in the field are well aware of the studies on the mental and emotional problems of the unwanted child. We know that maternal and child health levels go up and infant mortality rates go down when children are spaced. We understand the correlation between poverty, level of education and family size; and many other things. But the irate mother of sixteen happy, healthy unplanned children who wrote me a poison pen letter when she saw a TV spot, and the offended woman who had an unplanned, unwanted menopausal baby, who turned out to be the apple of her eye and the joy of her husband's life, were not tuned in on this wave length. Our thirty second spot could not possibly begin to explain it clearly and, therefore, was not doing what we needed it to do.

We also found ourselves in the ridiculous situation where slogans and catchy phrases so well fitted for our cause are used by groups on the exact opposite side of the fence, who obviously feel they serve their cause too. "Quality of Life", "Basic Human Right", "Dignity of Man" and the word "freedom" are blithely used by friend and foe alike. In 1965, the national theme for the Planned Parenthood - World Population fund raising drive was "Reverence for Life". That very same year a group in Wisconsin called "Reverence for Life" was instrumental in blocking OEO grants which would have gone for family planning. This same group has vigorously opposed revisions in Wisconsin birth control laws and now all over the country is putting up an heroic fight against abortion. The public must sometimes be a bit confused.

I like to feel we have now reached a stage of security and maturity where we can state our case with honest simplicity and not get all tangled up with catchy words that please our Madison Avenue trained tastes, but may serve to confuse and detract. Dorothy Millstone of the Information and Education Department of Planned Parenthood - World Population has found in her many years of communication experience that the family planning publications most likely to hit home are those geared to inform rather than persuade. In Buffalo, we found this applied to TV spots too. We ran a study of two TV patient recruitment spots. One was a rather ambitious venture that showed real patients who told you in their own words what birth control meant to them. They were marvelous - authentic and sincere. The spot contained some factual information but primarily it was motivational. The other spot was completely informational. It rather simply showed what goes on in a family planning clinic and packed in many facts about the service. This informational spot was by far the most effective in terms of bringing in new patients, and the best liked by almost everyone tested. It seemed to contain what women wanted most to know and to soothe their qualms about coming to a clinic.

We continued the study by asking patients what they were most concerned about before they came to us for care. They were concerned about methods -- were they safe, would they work, would they affect their sex lives. They wanted to know about service - was it professional, was it medical, was it friendly. Cost was important and whether they could bring their kids. And over and over in some form came the message, "How would I be treated?" "Would you be concerned about my personal health and problems, or just give me a pill and send me home?" Some women who come to family planning clinics have had other clinic experiences and they are not always pleasant. Many patients do not religiously see a doctor once a year for a checkup. The doctor is reserved for moments of dire distress and they are not used to seeing him in his role of dispensing preventive medicine. Some come with guilt, many with fear and everyone is a little nervous when they walk into a new experience - particularly if it involves a pelvic examination which no one is really crazy about. Naturally, some factual information about what will actually happen, what services will be offered, and some feeling of friendliness and medical competence is important in helping patients make the decision to come for care.

The same holds true of pamphlets. Mrs. Millstone further assures us that the unadorned mimeographed sheet which contains the right information, given at the right time is fully as effective as any slick print job. We want to reach women in their child bearing years - particularly the young before they have unwanted pregnancies. With almost half the population of the United Sates under twenty-five years of age, the young become an even more obvious target. More and more we are going into schools and colleges and gearing our material to the young. And, across the country women are coming for contraceptive care at a younger age and with lower parity.

Men have not been completely neglected. Mostly, we have relied on them for community climate, fund raising and policy making. But we have always felt that birth control should be a mutual decision for couples and some of our literature and films are geared in that direction. This sometimes turns off the young who may not think in "couples" terms. We find we must develop special materials for them. More and more we talk about methods to mixed groups rather than just women, and see a growing concern and interest among men - not only for their own personal responsibilities but for the societal consequences of high fertility. With new research on male contraceptives developing and the increasing popularity of vasectomies, men may someday attain equality in this area.

Some cities have been able to get family planning literature into the marriage license bureaus (an obvious and ideal place) to be distributed along with the license. Unions, factories and businesses, particularly those with a high percentage of women workers who must avoid pregnancy to stay on the job, will cooperate in some areas by putting family planning pamphlets in pay envelopes and newsletters. In a few places, supermarkets will give out pamphlets at the check-out counters and churches have been known to tuck information into their printed order of service. Actually, we find motivation is highest and women most receptive to birth control information when they are approached following a delivery in the hopsital. Pre-natal and child health centers, day care programs, housing projects, neighborhood centers or wherever women gather, like the laundromat or beauty parlor, are also good places for dispensing information.

But, wherever pamphlets are distributed and no matter what else they say, where and how to obtain service is an absolute must. If no family planning service is available, there is always the private doctor and the drug store methods. These should be mentioned. Just don't leave people all motivated and informed with no place to go.

This is one of the most important points in communicating family planning. If all this magnificent communication is to serve people well, the services must be provided to go along with it. In the end, the primary goal is to get people to accept family planning enough to use it.

In addition to providing services, it is imperative that we communicate beyond pure patient recruitment. General family planning education is desperately needed to affect community climate so family planning can exist at all, to raise money so programs can be supported, to counteract harrassment so that service can function unhampered, or, perhaps, to educate voters about family planning legislation and legal reforms so that services can be broadened to meet the needs of the community. Though family planning education and patient recruitment are distinctly different types of communication, they are forever mutually dependent and tied together. One sets the stage for the other. None can be ignored if the goal is to be attained. This Spring we are going to get a great deal of help with general family planning education.

The National Advertising Council has selected Planned Parenthood - World Population for a concentrated campaign which will use all media all over the country. A minimum of 35 million dollars worth of free advertising will begin this Spring and run for two years. You are familiar with other Advertising Council campaigns: Smokey the Bear, Drug Abuse, and Traffic Safety. This is a major break-through for us.

Again we are not sure of the impact of this program. Awareness and acceptance of the concept and desirability of birth control does not guarantee that it will be practiced. There are still forest fires and use of seat belts has not increased to the hoped-for level.

There are many people who believe that motivational campaigns will have only marginal effects; that the human race is a stubborn lot and does not change attitudes and ways of living that easily. Others feel that social justice programs must be activated and this nation's social and economic structure changed before we can hope for drastic changes in procreation habits. Certainly all this is important and the family planning communicator must be concerned with the total package, but I am more optimistic about this national campaign. The reliable studies we have on the large numbers of unwanted children in this country, the fact that the poor do not want large families, and the knowledge that women at all levels will go to excessive lengths to terminate unwanted pregnancies, would indicate that this information is wanted and needed. Also, the timing is excellent. Concern for overpopulation and environmental problems is high and voluntary family planning is an obvious, humane, low cost, sensible course to take to begin to solve the problems. Furthermore, the campaign will be backed up by liberalized abortion laws in some states and increased availability of services provided by the newly passed Tydings Bill. If nothing else, the campaign will enhance awareness and encourage the changing of attitudes. It should legitimatize public discussion of family planning once and for all. It will serve as a rich background for our other efforts at the grass roots level and we will attain the broad coverage and multiplicity of approach which we have needed. Though TV probably comes the closest, no one means of communication can claim to make acceptors out of non-acceptors. It takes continuous exposure from a number of sources.

Because most of the national program will be directed through traditional channels, its full impact will be missed by some of the people we would like to reach. A segment of our youth do not read the establishment press or publications and often do not watch TV. Many get their information exclusively from the underground and student press. We have been a trifle nervous about trying to write for either and seriously question being associated with the four-letter-word, revolutionary press. On the other hand, we don't feel we can discriminate on the basis of political or pornographic convictions either. I think we must find ways to communicate in the underground. If we can't write for it ourselves, we can invite those who do to come to our centers to make sure they are correctly informed. What they write may not please your Board of Directors or money givers, but it will probably be very effective with their audience. If you decide to write for it, I don't really think it is that hard. We have a professional service to offer that is needed and wanted. I think we can say so without supporting the revolution or using offensive language. I am very sure that underground readers want the same information that anyone else wants. We need to relax and give it to them - even if its just a phone number.

Then, there are people who just don't seem to read - not that they are illiterate, they just don't read. San Francisco has had good luck using colorful slingers with a bare minimum of copy - an old fashioned means of communication, if there ever was one. Flashy, provocative posters, bumper stickers and buttons are popping up everywhere. My current favorite is a Henry Gibson poster with nothing but feet on it - dozens of pairs of feet. One tiny little space in the middle says "Every second and half - - - - by Henry Gibson. Welcome to the human race! Standing room only - - - - Shall I save you a place?"

Some delightful humor is developing around family planning and overpopulation. When cartoonists begin to recognize you, you know you have arrived. They are producing some very funny stuff that will go a long way toward alerting and interesting people in our cause. One I like has endless masses of people before a leader who announces, "We will dispense with the fertility rights this year".

The latest endeavor I know about is a magazine put out by Emory University Department of Obstetrics and Gynecology called "TRUE TO LIFE". They found that large groups of working women relate very strongly to true confession magazines and believe what they read. With this in mind, Emory produced a magazine with the identical format and the same type of stories written in the traditional, mediocre, simple style of the confession magazine. Birth control and abortion information are artfully woven into every plot in a soft sell manner. It is extremely well done, even down to the misleading titles: "Mama Made Me Do It, But She Didn't Tell me Why".

The information is medically correct and the impact highly motivational. I think there is little doubt that we should enter this area of the literary world. I do question the professionals producing the material, however. I think we have a more important role - one that will lead to wider distribution of information. I think our effort should go into educating and motivating those who normally write for this market. Thus, we naturally enter the field on a broader more permanent basis. In fact, if we really want to be thorough, we should be educating all sorts of opinion makers to inform for us in all the everyday things people see and hear. We should have a long talk with the Maytag Company who promotes those enormous families who use one washing machine forever. We should consider the funny papers and comic books that we know strongly influence many people. How about the next "Mother of the Year" having two natural children and a lot of adopted kids? Or maybe a mother with one or two children only. A woman who has found constructive sources of self fulfillment in addition to motherhood and is making other contributions to the world too. A few years of this, instead of that beaming mother of ten, and it might help to change attitudes toward family size, role of women and our responsibility to society.

In the midst of all these marvelous advances, however, statistics show that we still must rely heavily on the word-of-mouth and the one-to-one relationship for much of our patient recruitment - just as we did fifty years ago. The truth is that the most effective family planning communication at this time is the satisfied customer. Across the country in Planned Parenthood centers most patients come for clinic care because another patient, a friend or relative (who may also be a patient) told them about it or brought them. Forty-five percent of all Planned Parenthood patients in the country come for this reason. Only ten percent come as a direct result of public information, but we know that this figure is growing. In your region, the Great Lakes Region, 46.4 percent of all patients come because of the influence of a patient, friend or relative, and in the Northeast it is 56 percent. These women may have seen TV spots, read an article, pamphlet or car card, and, though we feel sure this serves to make them more receptive, in the end it is the close one-to-one relationship that finally moves them to act and come for care.

This says to us then that the best communication we can offer is the quality of the service we give. The way a patient's individual problems are met, the dignity and respect with which she is treated, and her total experience within the confines of the family planning center is important. Each patient serves as a potential ambassador to bring new patients, to provide community climate and to correct misinformation. Taking the time to correctly inform patients is time well spent. Patient communication can, however, be the most problematical area of all. It is fraught with pitfalls and takes a skilled hand.

In Buffalo this fall we had a young woman who held us responsible for her pregnancy. When she first came to us she had thought she could get pregnant if she took a bath after her brother, using the same bath water. She assumed the sperm swam around in the water and would impregnate her. We gave her an extensive counseling session, showed her a film on reproduction and birth control and assured her that she could not get pregnant in the bathtub. She went home and thereafter engaged in sex only in the bathtub because the one thing she retained was, "You can't get pregnant in the bathtub".

The sad thing about this story is that probably anyone in the field who works directly with patients could match it with stories of their own. Family planning people in India who demonstrate how a condom works by putting it on their thumbs recently were startled to find they had been taken literally and were responsible for pregnancies where men had faithfully followed directions and worn the condom on their thumbs.

Do not be lulled into thinking this silly sort of misunderstanding is confined to the low income or uneducated groups. Ignorance abounds. We continually fight stupidity at college levels too, where in spite of all that has been written about the pill, girls will still take one borrowed pill and go out on a date confident that they are protected against pregnancy. Because sex education is often poorly taught or non-existent in so many secondary schools, we find one of our first chores is to make up for this lack of background. Patient orientation classes and birth control educational programs in the community all start with a word on basic reproductive anatomy and some mutually understood terms - just so we can begin to explain how birth control works. This is necessary on all levels and with all ages.

Capitalizing on the one-to-one idea of communication has given us one of our best methods of recruiting patients. Social work aides (auxiliary workers or outreach workers) go door to door or wherever women gather to tell them about available services. These women are generally indigenous to the areas in which they work and other women find it easy to relate to them. They may or may not have an education, but are carefully trained by the family planning agency. They and the Planned Parenthood worker, who goes to the maternity hospitals to talk to women at bedside, account for the next largest number of patients coming to clinics.

This approach was, and still is, being used with tremendous success in Louisiana which has conducted a state-wide family planning program that is looked to as a model for other states. Not a word about their clinics appeared in the paper or in any other media. An agreement had been reached with the Catholic Church that the program would not be opposed by the church if no mass media carried information on behalf of contraception. So workers went out into the community and nurses into the hospitals to inform on a one-to-one basis. The results have been impressive and about 3,000 new patients are attracted to the program each month. The need was there, the service was there, and the communicators brought the two together.

Beyond our own patients and workers, we need allies - knowledgeable allies who in the course of their regular jobs also work on a one-to-one basis and come directly in contact with people who may need and want birth control. Any agency that possibly can, spends a good deal of time and effort educating and training allies - welfare workers, public health personnel, nurses, social workers, clergymen, school counselors - anyone in a position to inform.

Speeches in the community bring good results too. These are not one-to-one contacts, but they are face-to-face communication and particularly effective with young mothers' groups and students. Students readily accept service if it is needed, but often go beyond this. They will raise money for you, influence the starting of on-campus service, disseminate birth control information, run educational programs or, as in Buffalo, end up as enthusiastic members of Board Committees and give many hours of volunteer time to the Center. Many colleges produce their own materials and, by and large, they are excellent.

Communicating family planning then boils down to five major areas: (1) The provision of quality service and skilled personnel; (2) Programs to train and inform others in appropriate disciplines to do effective family planning communication; (3) Wise use of mass media to set the climate, motivate and inform; (4) The development of new avenues and techniques of communication to reach the unreached; and (5) The correlating of family planning and population-ecology education with patient recruitment so each will promote the other.

Out of all the thousands of words you have heard from me this morning, I guess if I had to pick one thing for you to remember that could serve as a good guideline to you, I would choose the message used in the dramatically successful family planning program in Jamaica. It is my idea of a most straightforward, succinct and effective bit of communication. Billboards and other media carried only six words and the address of the local clinic. Everyone understood it and it applies to us all. They simply said, "You don't have to get pregnant".

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Effects of New York's Abortion Law Change

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Although laws and attitudes concerning it have become increasingly liberal in the past five years, abortion is still a controversial subject in many areas of the United States. Therefore, before I talk about the effects of the New York State Law, I believe you are entitled to know my own feelings regarding abortion. I will state them briefly. I believe that every woman should have the right to decide whether or when to bear a child, and that she should not be subjected to coercion of any sort in arriving at this decision. I believe that abortion is strictly a medical matter, and that there should be no laws specifically concerned with it. I believe that abortion should be an integral part of any good maternal health program.

I realize that there are many who, for philosophical or religious reasons, consider abortion immoral. Others believe that compulsory motherhood is immoral. I see no reason for either group to impose their views on the other. The late Cardinal Cushing stated it beautifully in 1965 when he said: (1) "Catholics do not need the support of civil law to be faithful to their own religious convictions and they do not seek to impose by law their moral views on other members of society."

There are three methods by which people can limit their reproduction: contraception, voluntary sterilization and abortion. I feel very strongly that whenever possible, unwanted pregnancies should be prevented rather than terminated. But until such time as a completely effective and safe contraceptive is developed and universally available, or until simple, cheap, and preferably reversible sterilization techniques are developed, abortion will continue to be needed and used.

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(1) Richard Cardinal Cushing Statement published in The Pilot (Boston) March 6, 1965

With this introduction, let me attempt to describe the abortion situation in New York.

For more than one hundred years, New York State had one of the most restrictive abortion laws in the United States. Suddenly, on April 10, 1970 the State found itself with one of the most liberal abortion laws in the world, to take effect July 1, 1970. The new law is short and direct. Essentially, it states that abortion is a matter to be decided upon by the woman and her physician. It contains only two restrictions. One, abortion must be performed by a licensed physician. Two, a physician may perform an abortion on a woman who requests it, up to the twenty-fourth week of pregnancy. After that an abortion may be performed only if the pregnancy endangers the mother's life. The law also states that no physician may be forced to perform an abortion against his conscience. There is nothing in the law dealing with consent of parent or spouse, no mention of the age of the patient. There is no residency requirement. Office abortions are legal.

In other words, the State of New York awoke on the morning of April 10, to find that in the matter of abortion it had suddenly leaped from the middle ages to the late Twentieth Century. Reactions were mixed. For those physicians, attorneys, organizations and ordinary citizens who had long worked for abortion reform, it was a moment of triumph. Now, at last, abortion would become just another medical procedure, to be decided upon by the patient and her physician. Or so they thought.

Those organizations which had opposed any liberalization of the abortion statutes were bitter, and vowed to double their efforts to restore the restrictive law and to punish those who had voted for change. To some extent they have succeeded. The courageous assemblyman who cast the deciding vote in favor of repeal was defeated in the primary election. Several other legislators who voted for repeal were defeated in the November elections. The battle is certain to be continued in the present legislative session, and it is certain to be bitter.

The New York State Medical Society was opposed to outright appeal of the old statute. It favored some liberalization, but opposed "abortion on demand". Parenthetically, I might state that I have always had difficulty in understanding why it is called abortion on "demand". No person, medical or otherwise, refers to annual physical exams on "demand", prenatal care on "demand", cancer smears on "demand". The medical profession is urged to perform those services on "request" - and the public is urged to request them. Why not "abortion on request"?

At any rate, the New York State Medical Society worked closely with the State Department of Public Health and with the New York City Health Department to develop abortion guidelines. As a result, before the law took effect, these agencies developed guidelines considerably more restrictive than the State law. The guidelines required that abortions should be performed only in accredited hospitals, in hospital out-patient departments, or in facilities approved by the State Department of Public Health.

These guidelines do not have the effect of law unless they are incorporated into the State or City Health Codes. However, since they eliminate office abortions as accepted practice, any physician performing abortions in his office is vulnerable if he should be sued. Nevertheless, a great many office abortions were performed between July 1 and October 19, 1970. On that date the City of New York incorporated their restrictive guidelines into the Health Code, and New York City physicians performing office abortions are now liable to one year in jail and a $1,000 fine. The State guidelines have not yet been incorporated into the State Health Code, hence, office abortions are still legal in all parts of the State except New York City. One result is that many physicians in the City are opening branch abortion offices in the suburbs.

It is only fair to mention that minimal requirements regarding equipment, anesthesia, availability of blood and emergency services, as well as the restrictions on abortion adopted by the City and State Health Departments are intended to safeguard the health of the patients. However, opponents of abortion have attempted to circumvent the new law in a number of ways. Throughout the State, hospital boards and administrators have arbitrarily ruled that no abortions shall be performed in their institutions. Others have set a very low limit on the number of abortions that may be performed per week. Some hospitals refuse to accept patients more than eighteen weeks pregnant. In at least one institution the nurses threatened to strike if abortions were performed in their hospital. They prevailed. In several hospitals, the young physicians in training rebelled against performing abortions. They were in training, they said, "to acquire major surgical skills, not to spend their time performing abortions". One might remind them, of course, that they are in training to learn to meet their patients needs. However, some hospitals solve this problem by paying their resident staff a fee for each abortion. This seems to make the operation more interesting.

You will see from what I have said that although the Law provides that any woman less than twenty-four weeks pregnant should be able to obtain an abortion by consulting her physician, many agencies and individuals have succeeded in modifying and even partially negating the law. Nevertheless, I believe that on the whole, it has been remarkably successful.

It should be recognized that a three month period to plan the orderly institution of abortion services was difficult and challenging. How many women would request abortion? No one could be certain. How many women with no income, or low income, would request service at municipal hospitals? Again there was no certain answer. Therefore, hospitals which planned to perform abortions were deeply concerned about the availability of sufficient beds, operating time, and staff with which to cope with the demand. Estimates concerning the number of possible abortions varied between 50,000 and 500,000 per year. Dr. Joseph Rovinsky (2), Chairman of the Department of Obstetrics and Gynecology at Elmhurst Hospital, a municipal hospital in Queens County, made a careful study of the problem, and concluded that the demand for hospital abortion in New York City would probably be between 60,000 - 120,000 per year, and that the number of indigent or low income patients would be approximately 30,000 - 60,000 per year. These estimates appear to be borne out in Table I, which indicates the total number of hospital abortions reported from July 1 to December 4, 1970. It should be noted that for many reasons (lack of clerical help, delays in reporting, etc.) these figures are not complete. Nevertheless, on the basis of the available figures, one can predict that indigent and low income women will request between 30,000 and 35,000 abortions during the first year of the new law.

Table II shows the place of residence of those receiving abortion. Forty-four percent of the abortions performed in New York City hospitals have been at the request of women from outside the State, but ninety-five percent of the low income patients - those requesting voluntary hospital ward service or municipal hospital service, are from New York City or State.

The greatest number of out of state abortion requests came from Canada and New Jersey. Ranking second was Massachusetts. This is particularly interesting because Massachusetts has terribly restrictive laws regarding both contraception and abortion. I am sure that Mrs. Pilpel will describe them to you. But judging from the actions of several thousand Massachusetts women, it is doubtful that the finger of the legislature is accurately recording the state of the public pulse.

Unfortunately, the statistics concerning abortion in New York State as a whole are disappointing. In theory every abortion, no matter where performed, must be reported, and hospitals in New York City are probably reporting abortions quite accurately. The reporting and tabulating are slow. But there are a great many abortions which are not for a variety of reasons, which I will explain, being reported at all. The number of reported abortions, and an estimate of unreported abortions are indicated in Table III. Three independently operated clinics ("B", "C" and "D") have verbally reported to Planned Parenthood-World Population that they have performed approximately 16,325 abortions from July 1 to December 1, 1970. They have not yet been officially reported to the City. One other clinic has reported 4,435. There are many more "clinics" or "groups" operating in and near New York City, which have not reported. An unknown, but certainly large number of abortions, have been performed in physicians offices in New York City and New York State. Very few of these have been reported.

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(2) Abortion in New York City - 1 July 1970 - A consideration of the practical problems which may follow elimination of statutory restrictions on termination of pregnancy - Joseph J. Rovinsky, M.D.

The State of New York, exclusive of New York City, has, for reasons that are obscure, not released monthly abortion statistics since August 1, 1970. Therefore, any attempt to estimate the number of abortions so far performed in New York State as an entity, are highly speculative. The reasons for non-reporting on the part of physicians who perform abortions in their offices are quite apparent. First, office abortions are now illegal in New York City. Therefore, in the City of New York, the doctor performing office abortions may be prosecuted. Outside the City, office abortions are legal, but are frowned upon by the State Department of Health. Consequently, the spectre of a malpractice suit will discourage reporting. And third, there are certainly some physicians who hope to circumvent the Internal Revenue Service, by neglecting to report the abortions they perform for cash. Hence, the estimates contained in Table III are conjectural. In my opinion, between 250,000 and 300,000 abortions will have been performed in New York State in the first year of the new law. However, the exact number may never be known, and this is tragic. Certainly, the people are entitled to know the results of this crucially important social experiment.

Who are the women who seek abortion? Table IV gives us some idea. The majority are less than twenty-five years of age. Unfortunately, at this time there is no data from New York City regarding the marital status of these patients. It will be forthcoming eventually. However, the State of New York has reported that fifty-three percent of abortions have been obtained by unmarried women. Will abortion reduce the number of illegitimate births in New York? The answer appears to be affirmative. Table IV presents the number of live births (Column 1) and the number of out of wedlock births (Column 2) in New York City in 1969. These births are recorded by age of mother. This table also indicates the total number of abortions performed in each of these age groups (Column 3) in what would appear to be approximately the first two and one-half months of the new law (22,742 tabulated abortions out of 46,793 reported to December 4, 1970). Just under half of the tabulated abortions are known to have been performed on New York City residents; therefore, Column 4 indicates the estimated number of abortions performed in two and one-half months on New York City residents. Column 5 uses this information to estimate the number of abortions which will probably be performed on the various age categories of New York City residents in the first year of the new law. It can be seen that except for the very young group - under fifteen - the number of estimated abortions in all age groups greatly exceeds the number of out of wedlock births recorded in 1969. It seems most likely, therefore, that out of wedlock births in New York City will show a marked decline in the year July 1, 1970 to June 30, 1971. It also appears obvious that total births in the City will show a substantial decline in the same twelve months. But the actual statistics will not be available for many months.

We also need to know why married women seek abortion, and what their family size is at the time they seek it. Presumably some of this information will eventually become available. Sometimes the gears of the computer grind slowly.

What is the ethnic composition of women seeking abortion? The answer is partially indicated in Table V. In the low income group (Municipal hospitals and ward service in voluntary hospitals) there are 34.6% white, 53.2% black and 12.1% Puerto Rican. Of the more affluent patients, the overwhelming majority are white. It is difficult to understand the absence of "other" ethnic groups. Were there no Oriental or other Asian or Latin American women seeking abortion? This seems difficult to believe. Perhaps future figures will clarify this. At what stage of pregnancy did women obtain abortion? It is well known that abortion, in order to be safe, must be performed early. Table VI shows the gestational age at which abortion has been performed in New York City. In every type of hospital situation the percent of early abortions has shown a marked increase when one compares the five month figures with those of the first two and one-half months. Why is this? In my opinion there are two reasons. First, by July 1, 1970 when the law became operative, there were a large number of women who had "saved up" their abortions from April 10 when the law was passed. Therefore, in the early months of the law many women already more than twelve weeks pregnant sought abortion. Second, many organizations - Planned Parenthood, Abortion Rights Committee, the Health Department and others, have mounted a vigorous educational campaign, using leaflets, bus and subway cards, radio and television, urging women who wish abortions to obtain them early. This campaign appears, on the basis of the figures, to have been effective.

It is obvious, that education in this field is imperative. Table VII demonstrates that a woman who obtains an abortion when she is less than twelve weeks pregnant has 7.8 chances per 1,000 of complications, whereas her chances if she is more than twelve weeks pregnant are 30.3 per 1,000. The actual numbers of complications reported thus far are unquestionably low, because post-abortion follow-up is far from perfect, particularly in out of hospital abortions. However, the ratios are probably quite accurate. Therefore, it is apparent that the woman who procrastinates, or whose abortion is delayed beyond twelve weeks by hospital red tape, runs almost four times the risk of complications of the patient who is aborted early.

How dangerous to life is abortion? The answer varies with the conditions under which the abortion is performed, the duration of pregnancy, and the skill and training of the physician. Table VIII indicates the risks involved. All of the abortion deaths to this date have occurred in New York City. There have been a total of twelve. As a basis for comparison, we should note that in 1968 there were twenty-one abortion deaths, and in 1969, twenty-four abortion deaths recorded in New York City. One-half of the deaths occurring since July 1, 1970 are thought to have resulted from non-professional abortions. Nevertheless, they must be included in the overall calculations. And when these twelve deaths are related to the estimated total number of abortions performed in the State, the risk of death is approximately 13.7 per 100,000.

The maternal mortality rate in the United States exclusive of abortions is 24 per 100,000 births. (3) In other words, even using the uncorrected statistics, it appears that the risk of abortion is about one-half of the risk of childbirth. When we look at the risk of death for hospital abortions only, on the basis of reported abortions in New York City alone, the rate is 9.2 per 100,000 abortions. This risk is obviously decreasing - there have been no deaths from hospital abortion in approximately 25,000 cases performed in the weeks from September 15 to December 4, 1970. Hospital abortions are obviously becoming safer as women seek abortion earlier, and as physicians become more expert in dealing with the situation. This has been true in every country with liberal abortion laws.

What about abortion performed out of hospital? On the basis of the available figures there appears to be a definite risk involved in office abortions. At least two deaths have occurred as a result of attempted office abortions, in an indeterminate number of these procedures. But the figures available for free-standing clinics which specialize in abortion are very impressive. Four clinics in New York City have performed approximately 20,850 (Table III) abortions. There are many other smaller, but similar clinics located near the city and in other parts of the State. The Planned Parenthood Center of Syracuse, New York has established an abortion facility on its own premises. At this time they have performed approximately 300 abortions. These have been reported to the State, but the figures do not appear separately in our statistics. At any rate, no deaths have been recorded in the performance of approximately 20,800 "clinic" abortions. Unfortunately, there are no meaningful statistics relating to complications which have occurred in the New York City clinics, but there is some indication that the complication rate is higher than for hospital abortion. All of these clinics as a general rule limit their abortions to those women who are twelve weeks pregnant or less. However, since three of the four hospital abortion deaths occurred in early pregnancy, the record of the clinics is enviable. If abortion becomes widely available in many or all states, the performance of these clinics should be carefully studied. The free-standing clinic presents several possible advantages over hospital or office abortion. They can be operated economically; they eliminate the frustrating red tape and delay of hospital admission practices; the patient stay is ordinarily a matter of only a few hours; and it appears that they can be operated safely. Therefore, it might be wise, particularly in large metropolitan areas, to establish several clinics either on the premises of, or close to medical centers, where they could be completely equipped and could be staffed by adequate numbers of highly trained personnel. They could, in this fashion, serve as a part of the overall health care offered by the medical center.

(3) Mortality with Contraception and Induced Abortion - Christopher Tietze, M.D., Studies in Family Planning, Vol. 45: 6-8 September 1969

How much does New York abortion cost? There is no clear cut answer. The fees range from zero to $1,000. One clinic charges 0- $50; another 0 - $200; another recently started, and very well equipped and staffed, charges $185, but one day a week serves only low income women without charge. Municipal hospitals theoretically charge an all inclusive fee of $160 for an abortion. But if women are unable to pay there is usually no charge. Unfortunately, some municipal hospitals demand cash in advance from those patients who are not on Medicaid.(4) Voluntary and proprietary hospitals initially charged a minimum of $575 including physician's fees. However, in response to pressure from Planned Parenthood and other organizations, many of these hospitals are now charging between $300 - $350. It is obvious that commercial referral agencies, some hospitals, and physicians have been profiteering from abortion.(5) Others, it must be emphasized, have delivered excellent low cost services. The Attorney General of the State of New York is presently investigating two commercial referring agencies in New York City. *Some agencies*, although they make referrals to reliable abortion centers, are suspected of misinforming the patient concerning the cost of referral.(6) They inform the patient that the fee for referral is only a few dollars. But they collect the fee for the abortion in advance, and are thought to keep a considerable portion of this fee for their service. It seems likely that if abortion should become available in *many or all* of the fifty states, and if women eventually shed their sense of shame concerning abortion so that they do not seek it in desperation, the costs are certain to drop dramatically. The Medical Society of the State of Washington has recommended that the fee for abortion performed under twelve weeks should be no more than the fee for a diagnostic D & C ($100 - $125). It would have been helpful if the New York State Medical Society had made a similar recommendation.

How does a woman obtain a New York State abortion? If she is a resident, she should consult her physician, or a local hospital. If she does not receive adequate information from these sources, she should phone the nearest affiliate of Planned Parenthood or the nearest Clergy Counseling Service. An out of state woman who thinks she may be interested in a New York abortion should first consult her own physician, who may be able to make a referral (sometimes in her own state). If this is not possible, she will probably receive the most reliable information from Planned Parenthood (local or national) or from the Clergy Counseling Service.

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(4) The Unmasking of Hospital Abortion Performance in New York City July 1 - October 1, 1970. Clergy and Lay Advocates for Hospital Abortion Performance, 55 Washington Square South, New York.

(5) Legal Abortions: A Progress Report. Linda Nessel, *New York Magazine*, September, 1970.

(6) Article *New York Times,* P. 21, December 19, 1970

In summary then, the New York abortion experience illustrates the following points:

1. Hundres of thousands of women apparently want abortion. I believe that sooner or later this need must be met in all of the United States. The recent referendum in the State of Washington which repealed that State's abortion law, points one way to the future. The United States Supreme Court may conceivably rule restrictive abortion laws unconstitutional.

2. There is urgent need for public health reasons for accurate and detailed abortion reporting - we must know the numbers of abortions requested and performed; the age, marital and economic status, ethnic and religious characteristics of women applying for abortion. We need to know how many women request repeated abortion. We need to know more about the type and frequency of complications and their consequences. We need to know why affluent women with access to contraception, fail to use these methods effectively. We must have better post-abortion follow-up in order to be certain that every woman receiving abortion obtains contraception if she wishes it. And these statistics can be obtained in such a way as to maintain the privacy of the patient. We should strive to give every woman the chance to make her first abortion also her last.

3. We have already learned what many other countries have learned. Namely, that there is a definite risk connected with abortion. As yet, we have no data concerning the effect of repeated abortion upon future pregnancies. But others have found that the risk of bearing a premature infant increases in direct relationship to the number of previous abortions to which the mother has been subjected. Peel and Potts state that in Hungary premature birth occurs in ten percent of those pregnancies where the woman has never had an abortion. However, if the woman has had three or more abortions, premature birth occurs in twice as many, or twenty percent of the pregnancies.(7)

4. I believe the New York experience is beginning to indicate that in respect to early abortion, the safest and most economical abortions can be obtained in specialized, well equipped, well staffed clinics, which ideally should be located close to a first class hospital.

5. The performance of abortion in New York demonstrates what every physician knows and what every woman should know, namely, that to obtain

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(7) Textbook of Contraceptive Practice, Peel, J. and Potts, M. (1969) Cambridge University Press

a safe abortion, it must be performed early. The earlier the better! Therefore, there should be a concerted effort to educate women and men in this respect.

6. It appears that abortion in New York will cause a marked decrease in out of wedlock births. Prior to legal abortion, illegitimate births, with all of their tragic consequences, had been increasing at an alarming rate.

7. Abortion in New York seems certain to decrease the number of births in the State. This would be in line with the experience of Japan and Eastern European countries, where it has been demonstrated that if abortion is accessible, people voluntarily defuse the population bomb.

8. We must educate people, both men and women, concerning the safety and advantages of voluntary sterilization. For those individuals who are certain that they wish no children, or no more children, sterilization is less risky and more effective than either contraception or abortion.

9. Because abortion is the least desirable method of fertility control, we must bend every effort to develop safe, effective, cheap, universally available methods of both temporary and permanent pregnancy prevention. We must be sure that all human beings who have reached reproductive age have accurate knowledge concerning these methods, and that they know where and how to obtain them. If we achieve these goals then the need for abortion will be greatly diminished. It will then be necessary only when contraceptive measures fail, or when careless people fail to use them.

I am grateful to Dr. Bernard A. G. Weisl, Hospital Affairs Consultant, State of New York Department of Health, and Mrs. Freda Nelson, Principal Statistician, New York City Department of Health, for their cooperation in furnishing the statistics for this paper.

Suggested Reading

1. Abortion in a Changing World - R. E. Hall, Ed. - Columbia Univ. Press, 1970
2. Textbook of Contraceptive Practice, Peel, J. and Potts, M. (1969). Cambridge University Press
3. The Case for Legalized Abortion Now. Alan F. Guttmacher, M.D., Ed. San Francisco Diablo Press, 1967
4. Abortion - Lawrence Lader, Indianapolis, Indiana. Bobbs-Merrill, 1966

TABLE I

HOSPITAL ABORTIONS NEW YORK CITY
July 1,--December 4, 1970

TYPE OF HOSPITAL		NUMBER OF ABORTIONS	PER CENT OF TOTAL
Municipal		10,158	21.8
Voluntary		15,570	33.2
Ward service	3,471		
Private service	12,099		
Proprietary		16,340	34.9
Other		4,725	10.1
Total		46,793	100.0

ECONOMIC STATUS OF 42,068 HOSPITAL PATIENTS

	NUMBER OF PATIENTS	PER CENT
Total ward patients (low income)	13,629	32.4
Total private patients (middle & high income)	28,439	67.6
	42,068*	

*Economic category of 4,725 "other" patients unknown. (10.1% of total cases)

TABLE II

DISTRIBUTION OF ABORTIONS PERFORMED IN N.Y.C. BY PLACE OF RESIDENCE
(Based on first 22,742 abortions reported)

	NYC		N.Y. STATE (Out of City)		OUT OF STATE		UNKNOWN		TOTAL CASES	% OF TOTAL
	# Cases	%	#cases	%	#cases	%	#cases	%		
MUNICIPAL	3,462	94.7	27	0.79	35	1.0	128	3.5	3,652	16.0
VOLUNTARY WARD	1,947	85.0	73	3.2	232	10.1	40	1.7	2,292	10
PRIVATE	4,061	52.0	567	7.3	2,961	38.0	210	2.7	7,779	34.3
PROPRIETARY	1,782	19.8	298	3.3	6,810	75.7	109	1.2	8,999	39.5
TOTAL	11,248	49.5	965	4.2	10,038	44.1	487	2.2	22,742	99.8

TABLE III

REPORTED AND ESTIMATED NUMBER OF ABORTIONS IN NEW YORK STATE
July 1,----December 4, 1970

New York City

Hospital abortions reported	42,068
"Other" (including 4435 reported from Clinic A)	4,725
Clinic B (estimated)	11,000
Clinic C (")	2,500
Clinic D (verbal report to Planned Parenthood-World Population)	2,825
Hospital abortions performed -- not yet reported (estimated)*	4,800
Total reported and estimated New York City	67,918

New York State (exclusive of New York City)

Reported July 1, -- August 1, 1970	2,823
**Estimated August 1, -- December 1, 1970	11,292
Estimated total reported 7/1--12/4/70	82,033
Unreported office and clinic abortions Conservatively estimated at 10% of total reported and estimated	8,203
Grand total all reported and estimated abortions July 1, -- December 4, 1970. (5 month period)	90,236
Estimated total for a twelve month period New York City and State (90,236 x 2.4) 7/1/70 - 6/30/71	216,564

*Estimated by Hospital Services Administration November 1970

**This assumes that the abortions performed August 2 - December 1, 1970 were at the same rate as July 1 - August 1 (2823 x 4).

TABLE IV

TOTAL LIVE BIRTHS AND OUT OF WEDLOCK BIRTHS NEW YORK CITY 1969, COMPARED WITH ABORTIONS PERFORMED IN NEW YORK CITY HOSPITALS. (First 22,742 abortions reported -- approximate number performed in the first 2½ months).

	NEW YORK CITY 1969		NEW YORK CITY ABORTIONS 1970 (Performed and Projected)		
Age of mother	Live births	Out of Wedlock	Total abortions performed 2½ mos.	Estimated NYC* res. 2½ mo.	Estimated NYC* 1st year
Under 15	487	453	66	32	153
15-- 19	19,651	9,704	4,763	2,261	10,752
20-- 24	50,343	10,190	8,202	4,060	19,488
25-- 29	43,653	4,957	4,486	2,220	10,656
30-- 34	20,600	2,547	2,754	1,363	6,542
35-- 39	8,999	1,152	1,705	843	4,051
40-- 44	2,345	297)	682	237	1,137
45-- over	127	19)			
Not stated	16	6	84	41	197
	146,221	29,325	22,742	11,057	52,976

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* These estimates are based on the fact that the tabulation of these 22,742 abortions showed 49.5% to have been performed on residents of New York City.

TABLE V

ABORTIONS PERFORMED BY ETHNIC GROUP
(Based on first 22,742 abortions reported)

HOSPITAL	WHITE		BLACK		PUERTO RICAN		OTHER		TOTAL
	No.	%	No.	%	No.	%	No.	%	
MUNICIPAL	1,034	28.3	2,234	61.2	384	10.5	0	0	3,652
VOLUNTARY									
WARD	1,024	44.7	932	40.7	336	14.7	0	0	2,292
PRIVATE	5,878	75.4	1,695	21.7	226	2.9	0	0	7,292
PROPRIETARY	7,952	88.4	934	10.4	113	1.3	0	0	8,999
TOTAL	15,888	69.8	5,795	25.5	1,059	4.7	0	0	22,742

TABLE VI

ABORTION BY GESTATIONAL AGE -- CALCULATED BY WEEKS FROM LAST MENSTRUAL PERIOD

	July 1 --Sept. 15		July 1,--Dec. 4	
	Weeks Gestation		Weeks Gestation	
HOSPITAL	Under 12	Over 12	Under 12	Over 12
Municipal	43.3%	56.7%	64.0%	36.0%
Voluntary				
Ward	46.5%	53.5%	66.4%	33.6%
Private	68.4%	31.6%	76.1%	23.9%
Proprietary	66.9%	33.1%	79.4%	20.3%
Other	Not available		95.5%	4.5%

TABLE VII

COMPLICATIONS OF ABORTION
(First 39,282 abortions tabulated)

	Complication rate per 1000 abortions	
	Under 12 weeks	Over 12 weeks
Hemorrhage	1.3	3.0
Infection	1.4	9.3
Perforated uterus	2.4	1.5
Other	2.7	16.4
	7.8/1000	30.3/1000

TABLE VIII

DEATHS FROM ABORTION -- NEW YORK CITY AND STATE -- July 1, -- December 4, 1970

	7/1 -- 9/15/70	9/15 - 12/4/70	TOTAL
NEW YORK CITY			
In hospital	4	0	4
Out of hospital	4	4	8*
NEW YORK STATE (other than NYC)	0	0	0
	8	4	12

*At least 6 of these abortions are believed by the Chief Medical Examiner, to have been performed by non-M.D.'s.

DEATH RATE PER 100,000 ABORTIONS COMPUTED ON THE BASIS OF VARIOUS NEW YORK STATISTICS

	Abortions	Deaths	Rate/100,000
1 - Reported abortions in NYC	46,793	12	25.6
2 - Known abortions in NYC	67,918	12	17.8
3 - Estimated abortions in N.Y. State	90,236	12	13.0
4 - In hospital abortions NYC	42,068	4	9.2

ABORTION DEATH RATES/100,000 IN OTHER COUNTRIES

England**	41.4
Sweden**	39.2
Eastern Europe (Czechoslovakia, Hungary, Slovenia)	3.0

** These countries do not include in their statistics, abortions which have been performed under unknown circumstances. Using this method, and using the estimated total abortions in N.Y. State we would have 6 deaths - 90,236 abortions, or 6.6/100,000.

The Law and Birth Control, Sterilization, and Abortion

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To follow Mrs. Hutchinson and Dr. Rogers is not an easy job, especially since I thought I should not have a prepared script because developments on the legal side of family planning take place so quickly that as soon as I write a paper it's out of date. I am going to ask you to let me know a few minutes before my time is up.

First, I have a few, very brief comments on Dr. Rogers' paper. I agree with it entirely, of course, but I did want to stress a couple of points implicit in it.

With reference to what Dr. Rogers said about "where can you get an abortion in New York", it should be borne in mind that there is something in the City of New York called the "Family Planning Information Service" which is an interesting phenomenon. It is run by Planned Parenthood - New York City (which is the local affiliate of the National Planned Parenthood organization) on behalf of various City Departments. In other words, the Department of Hospitals, the Department of Health, etc. are all members of something called the "Interagency Council" and the Family Planning Information Service works under it. The Service has many telephone numbers; as Dr. Rogers said, it advertises on car cards, in newspapers and on radio and television. In other words, this is a referral service for which no charge is made (and I think that it is very important that people should know about it).

A second point I want to make arises out of, but was not quite within the compass of Dr. Rogers' paper, the fact that I think we should all remember that anti-abortion laws have not meant no abortions. Indeed, it has been reliably estimated that probably over one million abortions have been performed in the United States every year for many years. The difference between the situation now when sixteen states have changed their laws, and another twenty-three or twenty-four are considering doing so, including this one, is that abortions have surfaced - not that there are necessarily more abortions. Of course, there may be more, but I think it distorts the entire picture if you take the position that while abortions were illegal they weren't being done. They were being done. They were being done with a very high cost in terms of loss of life and limb, damage to mental health, flagrant disregard of the law, etc., for which complete statistics are lacking, but which studies indicate were the result of prohibitory abortion laws.

And finally, I should like to say a word about some of the attacks which have been made on the New York Abortion Law which, as Dr. Rogers stated, went into effect on July 1st. It was almost one hundred and forty years ago that New York first passed its anti-abortion law, yet some people seem to expect that within six short months that situation could be totally reversed with complete efficiency. Obviously, when something has been sub-rosa, criminal for well over a century, it is not reasonable to anticipate that a perfect mechanism for delivering the service will develop within six months. As against a century and a half of illegality, I think, and I think you will agree with me, that the experience in New York has been most heartening. We have made significant progress in the last six months and many of the rough spots of the law and the service have been ironed out. That makes all the more necessary the fact that we should concentrate on defeating the restrictive amendments to the New York Abortion Law which are now pending in the New York State Legislature.

As you probably know, the New York Abortion Law passed the lower house of the legislature by one vote. And ever since it went through it has been the subject of attack by a variety of people, particularly those who are within the fold of the Catholic Church. I will come back to that when I talk about the legal aspects of abortion. There are now something like nine amendments introduced, some of which would cut back the permissible abortion period to twenty weeks, or even to twelve weeks (which could make the new law virtually useless); some of which would impose a residence requirement; some of which would outlaw Medicaid for abortion; some of which would require abortions to be done only in hospitals, etc. There are a few amendments which look toward further liberalization of the law, such as its entire removal, or permitting abortion on request through the ninth month, but I don't think they'll pass either.

Now, let me get to the subject matter of my own presentation this morning. Mrs. Hutchinson mentioned some rather interesting stories about how contraceptives fail and I wanted to say that sometimes statistics on effectiveness can be distorted by something entirely irrelevant and unexpected I remember Dr. Abraham Stone, who was a pioneer in the area of family planning, being terribly distressed by one of his patients for whom he had prescribed a diaphragm. He had explained that she should insert it every night whether or not she anticipated, or did have, sexual relations, and could remove it in the morning. Although she seemed a reasonably intelligent woman and claimed she had done as he suggested, she became pregnant on three successive occasions. After about five years of increasing frustration, he determined to find out what was going wrong. He found that she had indeed done exactly what he had told her. Finally, he asked her again if she could think of any explanation. She said "No, I do put it in every night, I keep it in all night", etc. He then asked "How often do you have intercourse during the night". Her reply was "Never, my husband works nights; we only have intercourse during the day". This kind of thing, uncorrected, could result in statistics wrongly indicating a very low percentage of safety for the diaphragm.

The history of legal developments affecting family planning in the United States could have a number of very catchy sub-titles. It could be called "from rags to riches"; it could be called "from taboo to requirement"; it could be called "a modern version of the Cinderella story". The part of Cinderella would be played by family planning, the fairy godmother by scientific and medical advance, and the wicked stepsisters by ignorance and comstockery.

We must remember, first of all, that the laws applicable to birth control, sterilization and abortion in the United States were conditioned initially by nineteenth century conceptions of morality, having nothing to do with the Catholic Church, but stemming from our puritan heritage. The restrictive laws began to give way under the influence of medical developments, and finally five years ago, we got to what is for me the real point, i.e. that every woman must, in a democratic society, be recognized to have a constitutional right to decide whether, and when, to have a child. We now appear to be verging on a fourth era; we've gone from the stigmatization of immorality to the exception for medical practice to the recognition of constitutional right, and now we begin to hear from some that family planning in one form or another should not only be permitted but also should be required. I do not subscribe to that point of view but it does tend to show the enormous switchover - not to say reversal - in public attitudes which have reflected themselves in the laws applicable to the control of human reproduction.

Let's take the subject of birth control first. Until 1870 in the United States there were no laws on contraception and there was very little knowledge on the subject. In 1873 Anthony Comstock, a puritanical purity crusader, descended upon the Congress of the United States with a large supply of dirty French postcards, and what I assume were good intentions. He went around shocking congressman after congressman, senator after senator, and eventually persuaded Congress to pass the "Comstock Act" which made birth control illegal in the area of federal power (that is, the mails and interstate and foreign commerce). It prohibited the importation, transportation in interstate commerce and mailing, of any article "whatever for the prevention of conception", along with any obscene, lascivious, disgusting article, and any article for the performance of unlawful abortion. The matter had been discussed on the floor of both houses, and at one point Senator Roscoe Conkling got up and said he thought the Senate might as well take a vote as discuss the law any further, because he, for one, had no idea what it was designed to do, and doubted whether any other senator had either. Whereupon, the Congress enacted the law in 1873. If my latest information is correct, the Comstock laws were finally repealed the last week of this just past congressional session. For over twenty-five years I and many others have attempted to get the Comstock sections off the books with, until just now, very little success, despite the fact that all of the relevant Federal Government departments were in favor of their repeal - the Post Office Department, the Justice Department, the State Department, etc. Now at long last they are off the books and the Federal Comstock Law may be a thing of the past to which it should have been consigned a long time ago.

After the Federal Government passed the Comstock Law in 1873 in its areas of jurisdiction, about half of the states passed Little Comstock Acts. The most well known of these was the Connecticut Birth Control Law which went farther than all the rest and prohibited the use of contraceptives -a very difficult crime to detect.

Probably the next most stringent example of a Little Comstock Law is that of Massachusetts which goes Wisconsin one better; although both States prohibit the distribution of contraceptives to unmarried persons, under the Massachusetts law, contraceptives may not be distributed to married persons except on the prescription of a physician. This is true even of non-prescription contraceptives. However, the Federal Court of Appeals in Massachusetts just this last summer held the Massachusetts statute unconstitutional on grounds which I think apply equally well to the Wisconsin statute. The United States Supreme Court has been asked to review the Massachusetts case. It's interesting to note that the week before the Federal Court of Appeals in Massachusetts declared the Massachusetts statute unconstitutional, the Massachusetts State Supreme Court held the same statute constitutional. This resulted in a very interesting situation in Massachusetts because, theoretically, if the State authorities prosecuted a man for violating the law he could immediately cross over to the Federal Court and get out a writ of habeas corpus. This yo-yo reaction was not one the staid Massachusetts authorities thought made sense and the Massachusetts Attorney General has announced that he will not enforce the statute in Massachusetts, pending the decision of the United States Supreme Court.

Author's Note: It turns out that some small part of it is left which prohibits the distribution of unsolicited contraceptives and detailed information about them-prohibitions which can seriously hinder certain types of family planning approaches and programs.

I am sure you are all familiar with the situation here in Wisconsin where a three judge court first declared the Wisconsin statute on abortion unconstitutional, and where there is now an injunction against its enforcement. I have been told some further action is contemplated or will be taken by the Federal Court of Appeals in this area.

But getting back to birth control: there was very little forward movement with respect to the Comstock Laws until sometime in the 1930's. In the late nineteen teens, Margaret Sanger had just rescued a woman who was dying of an abortion because she had never been given, or been able to get, any family planning information. When Mrs. Sanger had successfully nursed this woman back to some kind of health and had talked to her about the necessity for birth control, the woman had asked her doctor please to give her something that would prevent her conceiving again. The doctor replied "Tell Jake to sleep on the roof", which reflects the general level of the birth control information given in 1916.

Starting in the 1920's, it became obvious that contraception was an increasingly important branch of preventive medicine. It was no longer possible to consider it only as a morality problem. More and more doctors were recognizing that, at least in health situations, pregnancy was often contraindicated for both medical and sociological reasons.

The first case I worked on when I started to practice was one involving the importation of vaginal diaphragms from Japan to Dr. Hannah Stone, the wife of the Dr. Abraham Stone I referred to before. I remember that Mr. Ernst, then my boss, now an esteemed partner of mine, said to me "You won't be any use to this firm for some time anyways so you might as well work on something that would interest you" He gave me the choice of several cases, one of which he described as follows: "You see, there's the Federal Comstock Law which prohibits the importation of any article whatever for the prevention of conception, and Dr. Stone has imported these diaphragms which are for the prevention of conception, and all you have to do is show that the law doesn't apply to her". At that point I thought it would have been much better if I had gone to social work or some other - any other - field than law school. But I had little choice but to see what I could find. I did unearth two precedents. One had to do with an ordinance in the City of Bologna (I think it was), Italy in the sixteenth century or so, which held that a law which prohibited the letting of blood on the streets did not apply to a leech who let blood for therapeutic purposes. The second "precedent" had to do with the importation of a very distinguished Anglican minister to preach at Trinity Church in New York. It had been alleged that the law prohibiting the importation of contract labor into the United States applied to this estimable gentleman because he did indeed have a contract with Trinity Church. However, the United States Supreme Court held that the letter of the law could not always be followed any more than it had been in Bologna in the leech case; that the statute must be given a reasonable construction. Relying on these precedents, we were actually able to persuade the Federal Courts in New York that notwithstanding the absolute ban of the Comstock Laws, they would not be invoked against physicians who sought to import or transport, or mail, contraceptives for the preservation of the life or health of their patients.

Gradually, we were able to enlarge the category of permitted exceptions to include nurses, social workers, ministers, lawyers, public health workers, community workers. The real coup de grace to the Comstock Laws came in 1963 when a foam contraceptive was advertised for family planning in nineteen national magazines with a circulation of thirty-one million lay readers. The St. Louis Postmaster in St. Louis where the company was located noticed that there were an awful lot of little packages going out from the company. When he discovered they all contained contraceptive samples, he read the Federal Law, found that no article whatever for the prevention of conception was supposed to be mailed, and stopped all of the packages from going out. They were being sent, incidentally, pursuant to a coupon which said basically, "I am married, my name is so and so, and I want to use the advertised product for family planning". At the time President John F. Kennedy was President, and his brother, Robert F. Kennedy, was Attorney General. Although Catholic, they were sympathetic with family planning and President Kennedy was the first president to call attention to the great national importance of family planning. When I went to Washington on behalf of the contraceptive company, the representatives of the Department of Justice and the Post Office Department understandably asked how these shipments from a manufacturer to the ultimate consumer could be permitted while the Comstock Laws remained on the books, no matter how many exceptions had been read into them. We who were working on the case had anticipated that that was what the governmental authorities were bound to ask so we were prepared with an answer and could assure them that we were not asking them to read the statute off the books entirely. On the contrary, we said, in any case where you can prove that a contraceptive is being sent for an illegal purpose, the statute applies. Asked to give an example, I suggested that if a known prostitute wrote to the company saying "I want to use your product for the plying of my profession", then the government could hear of this, and then possibly there would be a violation of the law. But here, we argued, the contraceptive was being sent in response to coupons saying "I want to use your product for family planning" and that is perfectly legal. The Federal authorities did hold that the contraceptives could be mailed in the absence of any proof of unlawful purpose and they ordered the St. Louis Postmaster to release all the shipments. I have often wondered whether he ever read a statute again.

A little over thirty years ago all of the birth control clinics in the State of Connecticut were "coincidentally" closed after they were denounced in Catholic puplits one Sunday as being in violation of the

Connecticut law. I worked on Connecticut birth control cases for twenty-five years thereafter before we were able to get the United States Supreme Court five years ago to declare that that Connecticut statute, which prohibited the use of contraceptives, was unconstitutional on a variety of grounds. It is this case, which has become known as the Griswold case, which is the basis for much of the development that has taken place in connection with the laws relating to abortion. I won't go into detail on all the Connecticut cases. I argued part of one of them and it was a fascinating argument. At one point, Justice Frankfurter turned to the attorney for the State of Connecticut and asked him whether he couldn't go into a drugstore in Bridgeport and buy a condom or other contraceptive. The attorney responded that he "would not do that, your honor", which led Justice Frankfurter to further interrogation to the effect that he was not asking the attorney whether he would do it, but rather anyone who wanted to could thus buy a contraceptive to which the reply was that the attorney didn't know, etc. The argument more or less continued on that basis and the case ended in a holding that the Connecticut statute was "a harmless empty shadow".

Thus, that argument did not yield the final decision. It was necessary to start one more case, number four, which wended its long way to the United States Supreme Court before the Griswold case was decided. Finally in that case, the Court decided that there is a basic constitutional right of privacy in matters related to marriage, family and sex.

After 1965, virtually all of the birth control laws fell in one way or another except for the hold-out states of Wisconsin and Massachusetts. There are now upwards of forty-five states in which there are family planning programs subsidized to at least some extent by services or money from state and local governments. The Federal money also goes into these states, and as Mrs. Hutchinson indicated with the passage of the Tydings Act, there will be more money available. However, as she also indicated, there are some five million low income women who should have access to family planning but who don't for one reason or another. So the work to be done in the birth control field is basically what Mrs. Hutchinson was talking about - increased communication and increased services, and, as Dr. Rogers said, better contraceptives.

The abortion picture is very different. Those of us who had been arguing that there was a constitutional right of privacy which embraced the right not to have children if you don't want them got nowhere prior to 1965 insofar as abortion was concerned. Abortion was a taboo subject. It was not discussed in the media; you couldn't talk about it on radio or television, or even for the most part from a public platform. In the late 1950's a prestigious group, called the American Law Institute, which consists of judges, law professors and lawyers drafted a model penal code, which contained a provision relating to abortion which at that time was revolutionary. It has come to be known as the American Law Institute proposal and its essence has since been enacted by thirteen states.

(It is proposed for this state.) The American Law Institute proposal provides that abortion may be performed not only to save the life of the mother (which was by and large the only exception to the statutory ban on abortion throughout the country), but also to preserve her mental or physical health, to avoid the birth of defective offspring, and in cases of rape or incest.

Thirteen states, as I have said, have enacted this American Law Institute proposal in one form or another into law. It has not, however, worked out very successfully. Some of the major states adopting it did not include all of the exceptions I have just mentioned. For example, in California, Governor Reagan insisted on striking from the statute the ground of averting the birth of defective offspring. The result is that the incidence of mental illness in California among pregnant women seems to have risen mightily. In many California communities, such as San Diego and to some extent, San Francisco, abortions are, in effect, being performed on request in large part based on the mental illness exception. However, in other communities, such as Los Angeles, abortions have been much more difficult to obtain. In Colorado, which was the first state to pass an American Law Institute proposal, the experience has not been good. Many of the hospitals outside of Denver have refused to do any abortions; many of the hospitals in Denver have a very small quota, or do none at all. In Maryland, where the abortion provision was taken out of the penal code and put in the code of medical practice, the experience has been better, but not sufficiently satisfactory to those who had advocated increased availability of abortion. Consequently, this past year the Maryland State Legislature passed a law repealing the abortion law entirely. This the Governor vetoed; but I am told that it will be reintroduced with some minor changes and that this time it may go through even if the Governor again vetoes it.

In addition to the thirteen states with American Law Institute type laws, we have four states that have in effect repealed their abortion laws. They are, in addition to New York, Hawaii, Alaska, and, as of election day 1970, the State of Washington. A popular referendum was held in Washington on the subject of the repeal of the abortion law. Even though several public opinion surveys had shown that such a referendum would probably fail, fifty-six percent of the voters in the State of Washington voted to repeal the law. I have been told by Washington residents that this percentage may in some degree be due to the excesses of the opposition to the referendum. I am told that the Catholic groups distributed posters with fetuses looking like babies being dumped into ash cans, called the proponents of the referendum murderers and the like with such vehemence that many people who didn't really care one way or the other were so offended that they voted in favor of the referendum. Thus, we have sixteen states with changed laws and at least another twenty-three in which legislative proposals for liberalization are pending.

Meanwhile, back in the courts interesting developments have also been taking place.

A year ago last September, the Supreme Court of California was called upon to interpret an abortion law like the present law of Wisconsin (which has recently been held unconstitutional). The California Supreme Court broke ground on the abortion impasse for the first time. It held the old California law unconstitutional on the ground that (a) it was too vague for any physician to understand what was meant by the provision that an abortion may be performed to preserve the life of the mother - does death have to be imminent - would a shortening of a woman's life be sufficient - would an adverse effect on the quality of the life of the women be sufficient, etc. In addition to declaring the statute unconstitutional on vagueness grounds, the California Supreme Court - this brings me to (b) - held that it was also unconstitutional because it violated the right of privacy of women in matters related to marriage, family and sex. Since then about eighty cases have developed in the United States attacking the constitutionality of the old abortion laws, i.e. laws permitting abortion only to save the life of the mother, and in a few the new, expanded American Law Institute type of abortion laws have also been held unconstitutional. Several of these cases are now pending in the United States Supreme Court, one of which will be argued next week. That case is the District of Columbia case where Judge Gerhardt Gesell, the son of the famous Dr. Arnold Gesell, held that the District of Columbia statute which permitted abortion for both life and health (the latter narrowly interpreted) was unconstitutionally vague. He also mentioned the basic right of privacy in matters related to marriage, family and sex. It is hoped that the Supreme Court will in this case invalidate the old type of abortion law, and if it does, the laws in many states may fall. Unfortunately, it is also possible that that case will be decided on technical or narrow legal grounds. It is also possible that the case could be decided on the "vagueness" ground alone and not with reference to the right of privacy. The District of Columbia law, in a sense, is even more vague than the preservation of life laws, because it says "preservation of life and health" and there is no clear definition of either. There are four other cases docketed in the United States Supreme Court, one of which, the case from Georgia, involves the constitutionality of an American Law Institute type of law. It would be possible for the Supreme Court to consolidate all of these cases and to hold that a woman's basic right of privacy in matters relating to family, marriage and sex prohibits any limitation of the grounds for which abortion may be sought. This does not mean that there cannot be any limitation on the conditions of abortion - the kind of thing that Dr. Rogers addressed himself to. In other words, I don't think that most of us contend that the state has no legitimate interest in seeing that abortions are safe, decent, etc. The Georgia Court held that the reform law there was unconstitutional because it specified permissible grounds for abortion, and that the reasons why people seek abortion are not any business of the state - I guess that's the simplest way of putting it.

With many cases pending, the courts and thirty-seven state legislatures, which have already either acted or are considering acting, you can see that this is a fantastically active movement. And when you remember that there was no success in getting the old laws modified until after 1965, you can see that we have been moving very rapidly as far as abortion is concerned.

We should remember incidentally that when this nation came into being, abortion before quickening was the common law right of every woman. So if you find opponents of abortion law who want to go back to the good old days, you should remind them that in the good old days abortion was available before quickening to every woman. And you might also remind them that the reason for the abortion laws appears to have been not primarily morality considerations, as was the case with the birth control laws, but health considerations. At the time the earliest anti-abortion laws were passed in the early nineteenth century, every surgical procedure was highly dangerous because there were no antibiotics, no antiseptics, etc. Consequently, abortion which was then resorted to very freely was prohibited except to save the life of the mother, the theory clearly being that the only circumstance in which you should risk your life by having an abortion was the circumstance in which you would risk your life by not having an abortion, i.e. where the abortion was done to save the life of the mother. That, of course, is no longer true. Today abortion is safer than childbirth and involves a risk no greater than a routine tonsillectomy. Consequently, the abortion laws are being maintained on the books, where they are being maintained unchanged for reasons that have absolutely nothing to do with the reasons for which they were passed. Dr. Rogers gave you some statistics about the relative safety of abortion and the fact that it is considerably safer when done early in pregnancy than childbirth.

I would now like to take a few moments to talk about voluntary sterilization. Voluntary sterilization has had a very different history in this country from abortion or birth control. Whereas, birth control was pretty much let alone by the law until 1873, and abortion began to be prohibited except to save the life of the mother in the early nineteenth century, apparently nobody got around to thinking much about sterilization - voluntary or compulsory - until well into the twentieth century. With reference to sterilization, neither the moralists nor the physicians got into the act early. It was the eugenics scholars who started thinking about the wonderful things that could be accomplished by sterilization during the first quarter of the twentieth century. At least twenty-eight states passed laws calling for compulsory sterilization, one of which has been declared unconstitutional by the United States Supreme Court; all of which, in my opinion, are unconstitutional. Their passage created a fad, or a phase of the type to which the United States is unfortunately quite prone from time to time. The trend toward compulsion in this area was given considerable impetus when the United States Supreme Court in the 1920's held that the Virginia Compulsory Sterilization statute was constitutional on the ground that - and you all know this quote - "three generations of imbeciles is enough". (Actually, I have learned just recently that there were not three generations of imbeciles, and that the third generation baby referred to was normal.) In any event, medical science and eugenics have proceeded far beyond the point of being sure about which qualities are inheritable and which are not. For a while, the trend was so strong that a bill was introduced into the legislature of a midwestern state which would have declared chicken stealing an inherited characteristic and imposed compulsory sterilization as a punishment therefor. A few years ago, the State of Oregon, which has been pretty liberal on social legislation, and has a relatively good abortion law now, passed a statute which provided for compulstory sterilization of certain inmates of state institutions who might threaten to become public charges (which, as I said before, is in my opinion clearly unconstitutional.) Just recently a bill was introduced into the Hawaiian legislature calling for the compulsory sterilization of all females with two living children.

Because compulsory sterilization is, I believe, anti-democratic and, according to the United States Supreme Court unconstitutional, at least in some contexts, the word "sterilization" has gotten a bad name. This is unfortunate because voluntary sterilization, as Dr. Rogers said, is probably the best method of birth control for those who don't want any, or who don't want more, children. Interestingly enough, since this is a johnny-come-lately in the area of family planning, there are few laws against it. Until recently only two states limited the grounds on which voluntary sterilization could be sought to reasons of medical necessity, which was broadly defined to mean eugenic and therapeutic. One of those states, Connecticut, has now repealed its law effective this year, leaving Utah as the only state in the United States which limits the grounds on which voluntary sterilization may be performed. You would think, therefore, that with the efforts of the Association for Voluntary Sterilization, the ZPG people, etc., voluntary sterilization would be available in this country to those who want it. But not at all. Hospitals and doctors have imposed severe restrictions on the availability of voluntary sterilization although there are no laws requiring these restrictions. Why this is so, I don't know - maybe partly because voluntary sterilization deals with sex, and sex often seems to scare the medical profession.

Apparently medical students are taught at school that there is, or was, a crime called mayhem and they are afraid that if they perform voluntary sterilization upon request, they will be found guilty of mayhem. Law students learn very little about mayhem because it has not been a meaningful crime for many years. However, I gather medical students apparently learn a great deal about it. Mayhem is defined as the deliberate infliction of injury on one's self or another in a manner that interferes with the person's ability to serve the king. Well, it does not seem to me that this is a highly relevant crime today. Nonetheless, the doctors are scared about it. So timorous are they, and so important a weapon in the family planning armory is this, that that not so radical organization, The American Medical Association, has on two recent occasions specifically stated that voluntary sterilization as a procedure performed on request and with the consent of the patient involves no legal issues different or additional to whatever legal issues are involved in any other surgical procedure.

Notwithstanding this fact, strict limitations are imposed on the availability of voluntary sterilization by doctors and hospitals, and in many communities, including, I gather, this one, voluntary sterilization is virtually not available at all. Since this is not a matter of legal prohibition, the question arises what can be done about it. Well, for one thing you can follow Mrs. Hutchinson's advice and communicate better. For another thing, a direct contact should be made by such organizations as Planned Parenthood and the Association for Voluntary Sterilization with the medical schools so that they stop waking up with a cold sweat at night worrying about mayhem. Perhaps most importantly, and what is presently planned, are suits against hospitals for refusing to do voluntary sterilization operations. Such a suit was started in Northern Westchester, on the outskirts of New York City, where they had the usual kind of rules where for a woman to obtain a voluntary sterilization she has to have more than a designated number of children in her particular age group. In the Westchester case, the suit was very effective in that as soon as it was started the hospital changed its rules. I cannot be sure, nor can anyone, that any future suits will be that successful. There is a suit pending in Oregon now; and a number of groups, including the Civil Liberties Union, are considering bringing a variety of cases to effectively open up this method of birth control for those who want it.

Now, I think I have used up all of my time, but do I have five minutes?

For the last five minutes, I would like to say what I think still needs to be done in the area of law for family planning, and what I think should not be done.

The first thing I think should be done I just finished talking about, namely voluntary sterilization should be made available by court cases, if necessary. Secondly, I think we must continue the trend in the abortion area and repeal all of the laws which limit the availability of abortion to certain grounds. I do not oppose laws which impose reasonable restrictions to assure that abortions will be safely done. But I have always found it highly peculiar that some of the most ardent population exponents would rather talk about compulsory sterilization than the repeal of the abortion laws. I want to make no invidious comments about such people, but I do want to point out that if you are really concerned about the population problem, then, as Dr. Rogers' figures indicated and as the studies in Europe indicate, you must get rid of the abortion laws. Abortion is the least desirable method of family planning, as Dr. Rogers said, but it is also unfortunately the number one method of family planning throughout the world. I am convinced that no serious dent will be made in the population problem until the abortion laws are repealed. I do not favor abortion law repeal on the ground that it will solve the population problem. In fact, five or six years ago we didn't talk about a population problem very much. I have always felt that the abortion laws should be repealed as a matter of individual human constitutional rights, but it just so happens that their repeal is also a necessary step from the standpoint of our population problems.

The next thing that is absolutely essential is that we change our laws with reference to the medical treatment of minors. Over half of the states have already done so to some extent. Those of you who are involved in health services know that doctors are almost as afraid of treating minors as they appear to be of being accused of mayhem. Maybe somewhat more. They fear that minors cannot give effective consent to medical treatment; that, therefore, a doctor who prescribed for a minor in the absence of parental consent may be guilty of a technical assault and malpractice. Many doctors, therefore, will not treat minors in the family planning field - neither birth control or abortion - without parental consent. In many cases, of course, parental consent is unobtainable for a variety of reasons. Sometimes children entirely alienated from their parents don't even know where they are. Sometimes if you say to a minor "you have to get your parents' consent", the minor will disappear into a back alley somewhere and have an abortion done by a totally nonqualified person rather than tell her parents.

A preamble to a New Jersey statute states these are peculiarly sensitive subjects which are not necessarily appropriate for discussion between parents and children. Perhaps partly in recognition of this fact, over half of the states have basic laws dispensing with any requirement of parental consent for all or some types of medical services to minors. Some of these laws refer only to V.D., like the New York law which specifically states that doctors may treat minors for venereal disease without parental consent or knowledge.

Other states have made express exceptions for family planning services to minors, services to minors related to pregnancy and childbirth - different words are used in different statutes, but many of them give minors the right to medical services in the field of family planning and prenatal care without parental consent.

Recently some states have gone the whole way. The Pennsylvania law, for example, provides that minors seventeen years of age and older may give effective consent to medical treatment without parental consent for all services. It also provides for medical services to be given to minors of any age without parental consent when, in the judgment of the physician, obtaining the consent would be detrimental. A bill to substantially the same effect has already been introduced in the New York legislature.

But whether you choose the more limited approach of no parental consent needed in the area of family planning, pregnancy and abortion, or the complete approach of no parental consent needed where a minor is of a certain age, or where the failure to give the service would result in a health hazard, it is clear to me, and it was clear from what the other speakers have to say today, that unless family planning services are made available to minors without parental consent, you are not going to solve the problems in this area. Forty percent of illegitimate births are teenagers (that was only two or three years ago, it's probably more now) and the harm which flows from them to these children and to society is incalculably great.

Now the last thing I would like to mention is the recent talk there has been about the need for compulsory birth control, or compulsory sterilization, or, I suppose, compulsory abortion, although I haven't heard that mentioned.

It is typical of this approach that, for example, in an article in the American Bar Association Journal where compulsory birth control for teenagers is suggested, it is never pointed out that the same minors who, according to the article should be forced into a doctor's office to have an IUD inserted, don't have the right in that particular state to get family planning services by asking for them. Apparently the ticket for a minor to get family planning services in many states without parental consent is one illegitimate birth. Once there is one illegitimate birth, most of the legal bars are down. There seems little doubt that we should - we must zero in on the question of medical services to minors in the family planning areas.

If we do all of the things that all of us this morning have recommended, if we change the abortion laws, make birth control available, make voluntary sterilization available, and clarify the situation to make medical services to minors freely available, I do not think we will have to talk about compulsory anything. I still believe as a basic principle of American constitutional freedom that people have and should have a right to decide when and whether to have children. I am convinced that if contraception, abortion and sterilization were freely available, we would not have any need for coercion or compulsion.

In any event, until we have made voluntarism in this area a fact, freedom of choice should be our aim. If sometime in the future it appears that voluntarism will not work, there will be plenty of time to talk about coercion or compulsory methods. In the meantime, it seems to me that conferences such as this and people such as you may well bring about a state of affairs in which voluntarism can always remain the keynote in family planning matters. For the evidence is clear that people want fewer children. If we make this possible, I am sure we will never have to make it mandatory.

SESSION TWO

Friday, 8 January, Afternoon
Beaumont Motor Inn

Session Chairman:

Dr. N. B. G. Taylor
Chairman, Population Dynamics Concentration
College of Human Biology
The University of Wisconsin - Green Bay

Speaker and Panel Members:

Dr. Frank Shubeck
Dr. Richard M. Fontera
Mrs. Jean K. Hutchinson
Dr. Walter Rogers
Mrs. Harriet F. Pilpel
Mr. John Van Miller

International Postpartum Family Planning Program

Frank Shubeck, M.D.

Director, International Postpartum Program
The Population Council

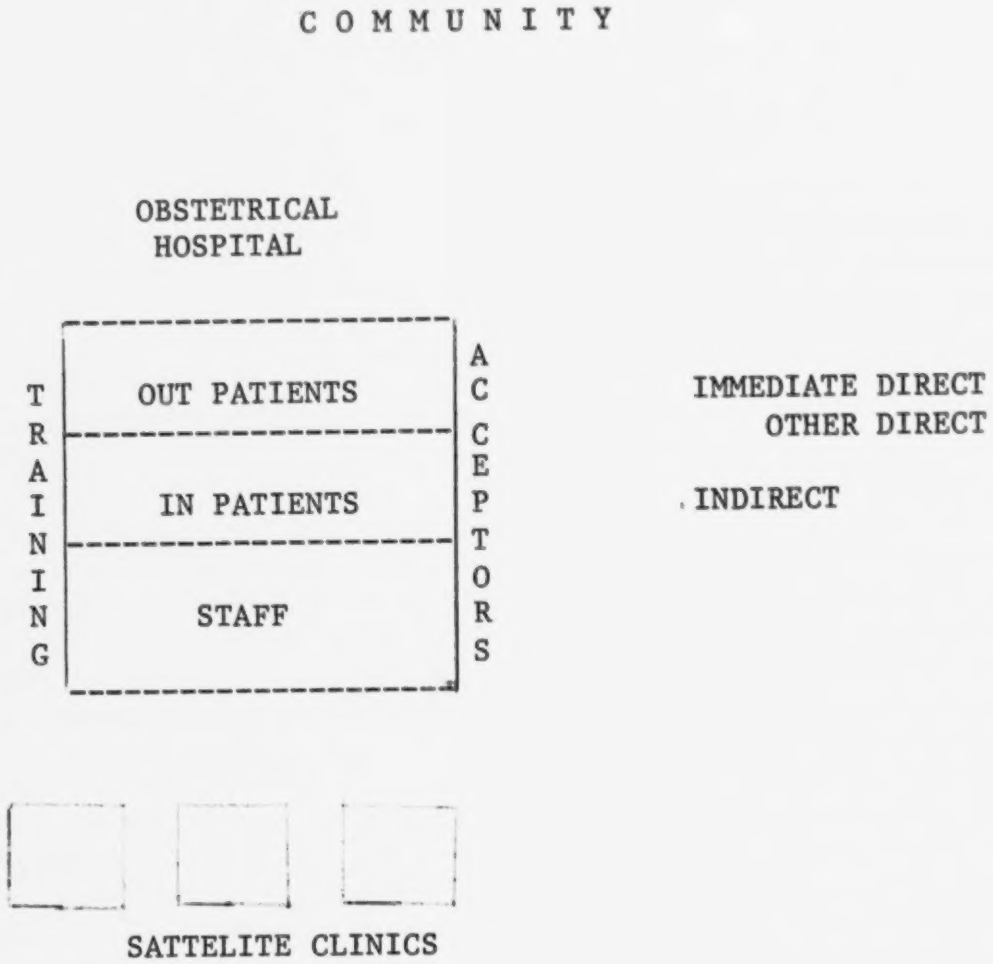
The International Postpartum Family Planning Program is a world-wide effort to introduce and promote effective contraception among the population in a community by focusing on the delivery, abortion and other obstetrical cases in participating hospitals.

Once pregnant, regardless of the type of termination, a woman has demonstrated her fertility. If she does not practice contraception, she is likely to become pregnant again rather soon after delivery or abortion. Polgar and Rothstein, studying four low-income areas in New York City, reported that twenty-two percent of women with two or more pregnancies had an average interval between conceptions of sixteen months, or about seven months from termination of one pregnancy to conception of the next. Reports of the India-Harvard-Ludhiana Study and others indicated essentially the same behavior. It would seem reasonable, then, to concentrate efforts to convince women to accept contraception shortly after termination of pregnancy so as to lengthen the interval between gestations.

The program is sponsored by governments and by local and international agencies, including the Population Council. Asian, African, and Latin American hospitals have joined the program since its initiation in 1966. The Population Council coordinates, advises, evaluates, and provides financial assistance to programs whose local resources are temporarily insufficient. The results of the past years have encouraged medical officials to introduce the postpartum approach into their own local hospitals.

The program intends (1) to provide information and education (I&E) about family planning during the antepartum period, during the hospital stay, and during the postpartum period; (2) to provide service to the patients, either during the time they are hospitalized or later in the postpartum period; and (3) to provide information and education and service to women who were not obstetrical patients, but who heard about the program from whatever source. The aim is to reach as many women at risk as possible, as in any proper health program.

The following chart elaborates the intent of the program.


COMMUNITY
OBSTETRICAL HOSPITAL
TRAINING
OUT PATIENTS
IN PATIENTS
STAFF
ACCEPTORS
IMMEDIATE DIRECT
OTHER DIRECT
INDIRECT
SATTELITE CLINICS

The outside irregular line represents a community or that part of a community which is served by a hospital. For example, the community may be the entire metropolitan area of Caracas, Venezuela which is served by the largest maternity hospital in the world, the Maternidad Concepcion Palacios (MCP), at which are delivered annually about eighty percent of all the babies in Caracas. For the year 1969, about 52,000 deliveries and abortions were performed. Although a hospital which provides services to the community may be a general hospital with a maternity unit, in the case of Maternidad Concepcion Palacios, it is almost exclusively a maternity hospital.

Women from the community come to the hospital for maternity service. This is the first important advantage of a postpartum approach over other types of programs. The women have an incentive, the proper conduct of their pregnancy, the belief that their own health during the pregnancy and delivery and that of their newborn child are best handled at the hospital. It is unnecessary to exert effort to locate these pregnant women and encourage them to attend a family planning clinic. Such women of proven fecundity are attracted to the maternity hospital, especially if the hospital has a reputation for providing good service. If the maternity care at the hospital has been acceptable, knowledge of such a "good thing" spreads through the community rapidly.

The pregnant women may come to the hospital

(a) for routine prenatal care; or

(b) because of past, current or anticipated complications of the pregnancy; or

(c) for delivery only, the prenatal visits having been made at a satellite health center.

Using MCP again as an example, most of the in-patients receive prenatal care at one of the thirty city health centers and are sent or come to the MCP only for delivery. Most of the women who seek postpartum care will return to one of the satellite clinics.

If a hospital conducts a prenatal clinic, there is opportunity to provide I&E about family planning to the pregnant women who attend. Many women may make more than a single visit to the prenatal clinic, thereby having an opportunity to get reinforcement of a previous message about family spacing or limitation or to ask questions, or to bring consent forms signed by their husbands. At the Victoria Jubilee Hospital in Jamaica, about 200 - 250 women each day visit the prenatal clinic, six days a week. It would seem appropriate to concentrate I&E efforts at such clinics.

Another advantage of a program associated with pregnancy is that motivation to accept family planning may be greater than at other times. In fact, there are family planning promoters who consider this motivation as the best reason for conducting a postpartum program. A woman who recently has had the discomfort and anxiety of a termination of pregnancy, either by the birth of a child or by an abortion, is apt to be more receptive to the concept of family spacing or of family size limitation. The combined attraction of a hospital plus the high motivation to accept family planning associated with pregnancy should be enough reason to promote this concept world-wide.

The hospital, then, is a place of convergence for pregnant women. The out-patient prenatal clinics (and/or the satellite clinics) provide opportunity for I&E.

The women who are delivered remain in the hospital as in-patients for a variable period of time from four to six hours, as in the case of Farah Maternity Hospital in Teheran, Iran, to about ten days in most places for those women who have had abdominal delivery (Cesarean section). However, the usual hospital stay is twelve to thirty-six hours for uncomplicated deliveries.

While as in-patients, both I&E and service may be provided. Probably each woman should be seen by a motivator who provides the family planning message and arranges an appointment for either a return visit to the family planning clinic for acceptance of a contraceptive method, or for such service while in the hospital. An intrauterine device may be applied, injections may be given, or a sterilization operation may be performed prior to discharge from the hospital. Women who accept a method after delivery and prior to discharge from the hospital are designated as immediate direct acceptors. Women who accept a method up to three months after termination of pregnancy are called direct acceptors.

Within the community are women who are in the reproductive age group who have not had a termination of pregnancy within the past three months. Many of these women hear about the family planning service that can be obtained at the hospital family planning clinic. If they accept a method at the hospital, such women are called indirect acceptors.

INFORMATION AND EDUCATION

A variety of methods to give I&E to pregnant women have been tried. Person-to-person contact is thought to be the best, but group methods need to be tested. Some hospitals use movies on the wards, others give group talks, while still others use public address systems. In general, the group and mass media are followed by personal contact to arrange for an appointment to return either to a family planning clinic in the hospital or to a satellite clinic. A few places have posters in the clinics, have distribution of printed materials, or have movies shown to groups during the prenatal visits. What seems to work well in a hospital generally is influenced by the enthusiasm and effort generated by the hospital staff.

STAFF

Experience has shown that the staff required to conduct a good program at each hospital with 3,000 to 5,000 obstetrical cases consists of a physician, one or two nurses or nurse-midwives, one or two social workers or motivators, and one clerk. The physician ordinarily supplies leadership and direction as well as service. Sometimes this role is fulfilled by a nurse or nurse-midwife, particularly in those countries where the nurse-midwives are more active and physicians are in short supply, such as in African countries. The nurses may give the I&E, assist the doctors in providing the service, or may provide the service. In smaller hospitals, the nurses may also keep the records, make appointments and occasionally engage in the follow-up of acceptors or delinquents. The motivators contact the women to provide I&E and may also check on acceptors or on those who fail to keep appointments. The clerk is essential to arrange appointments, maintain records, complete report forms, and generally keep the clerical part of the operation going.

More staff are added for larger hospitals and, for those countries that have multi-hospital programs, a central, coordinating staff is necessary. Usually the central office has a physician-coordinator, perhaps an assistant, a secretary, bookkeeper, and a clerk.

SERVICE

The physician, assisted by the nurse, provides the service. No specific contraceptive method is advocated, although in a few hospitals a particular method may be promoted. Research activities may influence the choice of methods dispensed at some hospitals. Ordinarily, the IUD, oral tablets, sterilization, injections, and traditional methods, including the rhythm method, though the last is used with little frequency, are available.

At a few hospitals, IUD's are inserted into the women prior to hospital discharge. Despite the fact that many of the IUD's are spontaneously expelled, many are retained. Furthermore, most of those women who accepted an IUD (immediate direct acceptors) and had a spontaneous expulsion within the first week of insertion, return to the clinic for re-insertion.

An injection that lasts three months has the advantage of getting the woman and her newborn baby through what often is a difficult adjustment period. Usually by the end of three months, the woman has recovered from the pregnancy, and delivery, and the baby has grown to sufficient size so that it can be left with a neighbor while the mother returns to the family planning clinic for her next injection. Returning at intervals of every three months also reduces the number of return visits and thus decreases the numbers of women returning to the clinic.

Sterilization is gaining in popularity. The operation is usually considered irreversible, does not add appreciably to the duration of hospitalization, and may require only one subsequent visit to the postpartum clinic.

India has an All India Postpartum Program which advocates female sterilization. Funds have been made available to increase the number of hospital beds and operating facilities with an aim to sterilize annually about twenty percent of the delivered women at each hospital in the program. One large hospital in Hong Kong encourages sterilization, especially for those women who have had or may subsequently have a "high risk" pregnancy. On the other hand, a few hospitals in the program, notably in South America, perform no sterilization operations, In Colombia, while no sterilizations seem to be the rule, two hospitals are doing them with increasing frequency. Sterilizations, IUD's and injections of contraceptive drugs that last for three months or more, lend themselves well for application prior to discharge of the women from the hospital.

EVALUATION

Although not all hospitals conduct their programs in the same way, and local data forms vary, rather uniform data are collected and reported to the Population Council monthly and semi-annually.

The monthly reports consist of total obstetrical and abortion cases, obstetrical-abortion cases returned to the postpartum clinic, new direct and indirect acceptors by IUD, pill, female sterilization, injectable, other, revisits by old acceptors, IUD re-insertions and vasectomies. The semi-annual reports are age by living children tables. Recently we have also asked for a semi-annual narrative report. Fiscal and commodity reporting are also requirements.

The staff at the Population Council review the reports for completeness and consistency in preparation for data processing. Tabulations are issued quarterly and are sent to all participating hospitals for their review. These tables indicate to each hospital the level of performance and how one compares with another. Such data are, of course, quite useful for administrative purposes.

Although the program began with private funds at twenty-five hospitals in nineteen cities in fourteen countries, monies made available to the Population Council by the U.S. Agency for International Development have permitted expansion so that there are now one hundred twenty participating hospitals in eighty-six cities in thirteen countries. In addition, India at last report had fifty-nine hospitals in its program, and there are plans to expand to a total of one hundred fifty-one hospitals.

Of the original twenty-five hospitals, only nine remain in the program. The seven U.S. hospitals are being funded from other sources; the two India hospitals are now part of the All India Postpartum Program; the large Kandang Kerbau Hospital in Singapore is part of their National Program as is the one in Karachi, Pakistan; the hospital in Puerto Rico is part of the San Juan City program; the two hospitals in the U.A.R. and the one in Tokyo, Japan are being visited by Population Council staff to determine their current status; the program in Chile has been closed.

The expansion in Indonesia and a new program in Brazil are effective as of the first of January, 1971.

Data from the monthly reports have been tabulated up to the end of September, 1970.

1. Since the start of the program in 1966, there have been 1,707,868 obstetrical cases, of which 15.6% were abortions. Abortions by country range from 8% (Puerto and Singapore) to 27% (U.A.R.).

2. The total number of acceptors was 552,048 or 32.3% of obstetrical cases. Of the total acceptors, 307,580 were direct acceptors, or 55.7%. The range of total acceptors was 7% to 99%, and range for direct acceptors was 13% to 92%. This means that 45% of the acceptors who came from the community did not have a termination of pregnancy at least within the previous three months prior to acceptance, but had heard about the program directly or indirectly. Thus, for each direct acceptor there is an indirect acceptor.

3. The program has been mainly an IUD program. Forty-eight percent of the acceptors chose this method; 31.7% accepted the pill; 9.4% sterilization; less than 1% injectable; and 9.7% other methods, including traditional ones. Generally, no restrictions are placed on methods used at hospitals. The staff are free to use whatever method they believe to be best for each woman. All contraceptive agents approved by the U.S. Food and Drug Administration can be supplied by the Population Council. Thus injectables must be purchased locally with other than Population Council funds.

From some of the follow-up surveys done at a few hospitals, a few facts have been gained and will be reported in a monograph covering the first two years of the program. The method of sampling has been questioned but we believe these data will be substantiated by our recent International Postpartum Survey which was developed using better sampling techniques.

1. Family limitation rather than spacing of births is preferred among non-U.S. women of higher parity and with less education.

2. IUD's are accepted by older, non-U.S. women of higher parity with less education and who do not desire more children. The same can be stated for those who accept sterilization. Thus, pill acceptors are apt to be U.S., younger women, of lower parity, who have more education and want more children.

3. Pain and bleeding, especially the latter, result in removal of the IUD, the most common cause for discontinuation. Spontaneous expulsion is the next most common cause. Pill users discontinue firstly because of side effects and, secondly, because of "inconvenience".

4. Women who accept and discontinue a first method are apt to accept another method. Thus three-fourths of the American sample and forty-two percent of non-U.S. sample indicated that they were using a second method.

5. About three percent report being pregnant at the time of the interview. Younger, lower parity, pill acceptors who want another child are more apt to become pregnant.

6. Most women are satisfied with the first method chosen.

Data for Hong Kong from the International Postpartum Survey have been analyzed and a few comments can be made.

1. For all acceptors, first method continuation rates decline with time. Furthermore, continuation rates were higher in 1966 for the same interval as compared with 1969. Two factors may be operating:

   (a) The proportion of women who accepted the IUD has declined from about seventy-three percent in 1966-1967 to about five percent in 1969-1970. Concomitantly, the proportion of women accepting the pill has soared. There is now ample evidence that continuation rates for oral contraceptive acceptors are very much lower at a given interval than for IUD acceptors.

   (b) The proportion of women who at acceptance had only one living child has risen from thirty percent in 1966-1967 to sixty-three percent in 1969. Most of these "low parity" women desire another child. Consequently, these women stop using a contraceptive method sooner than women of higher parity.

2. Continuation rates for all acceptors, all methods, are higher than for first method, indicating again that women will continue use of contraception though the first method accepted is discontinued. After four years, the continuation rates for all methods are more than double those who remain on the first method. Those women who accepted an IUD as the first method are more apt to be practising contraception four years later, even though the method may not be the IUD. This supports the earlier information that older, non-U.S. women of higher parity and less education are more apt to accept the

IUD. Such women are more interested in family limitation rather than spacing.

Data from the International Postpartum Survey from Southeast Asia (Hong Kong, Phillipines, Indonesia) have been analyzed for pre and post acceptance as to birth and pregnancy rates.

International Postpartum Survey

Birth and Pregnancy Rates
Prior To and After Acceptance

Year	Birth Rate Prior	Birth Rate After	Pregnancy Termination Rate Prior	Pregnancy Termination Rate After	N Prior	N After
1	684	30	784	46	582	584
2	584	82	665	110	360	370
3	544	90	607	113	134	144

The annual average birth rate for the year prior to acceptance was 684 and for the first year after acceptance was only 30. For the three years prior to and after acceptance, the rates are 544 and 90 respectively.

These are rather high birth rates prior to acceptance and very low after acceptance. The first year post-acceptance may be low because of the natural infertility factors of a physiologic refractory period, and lactation, or cultural taboos. The second and third year birth rates are nearly alike. Subsequent yearly average rates will most likely depend on IUD continuation rates. Other similar data from other countries have not been analyzed sufficiently for comparison.

COSTS

The average annual cost of a non-U.S. hospital program which has about 3,000 to 5,000 obstetrical cases is about $10,000. This is about $1.35 to $2.00 per obstetrical case. If we consider the cost per acceptor, this amounts to about $5 to $9, depending upon the non-U.S. country. Initial equipment, construction, follow-up, amount of I&E, training, meetings and travel can affect these costs, but may also influence the number of acceptors. These are direct costs, i.e., what external funding agencies put into the programs. How much the hospitals contribute directly or indirectly is to be a major study by the Population Council during 1971. Obviously all hospitals contribute space, equipment, personnel, time, administration, utilities, and the like. Recurrent costs, such as the use of oral contraceptives, add measurably to the total annual operating costs, not only to the amount of money spent for the agents, but to the time of staff who must dispense them.

SUMMARY

The postpartum concept implies that a woman is maximally motivated to accept family planning in association with a pregnancy. The use of a hospital in such a concept has the following advantages:

1. Leadership and administration are usually present and the efforts of part-time or full-time staff can be incorporated often easily into a program.
2. Facilities for providing contraceptive service generally are available or can be added at less cost than construction of a new building. Adding to existing facilities is likely to require fewer additional staff than a new facility.
3. Hospitals have "talent" available through other departments and these people can be incorporated into the programs, thus often providing additional health benefits.
4. Hospitalized women are "captive" and thus reachable, especially on a person-to-person basis, even though the hospital stay may be only a few hours.
5. I&E about family planning can be supplied at antenatal clinics, adding to the opportunity to repeat the message, etc.
6. The hospital, an "authoritative" source, may be able to have more influence on the women to accept a method.
7. Large waiting rooms generally have aggregates of women to whom the family planning message can be transmitted.
8. Clinic records may be readily kept as most hospitals have experience in this area.
9. Financial records of the program may not pose a great additional burden to an existing system at the hospital.
10. Hospitals may be appropriate areas for the conduct of research.
11. Hospitals are generally excellent places for training family planning clinical staff.
12. Hospitals can add family planning to their clinics as an extension of maternity service without creating a special family planning movement in "sensitive" countries.

13. Frequently hospitals are free of government bureaucracy.

The postpartum program is primarily an urban program but attracts women from the rural fringe areas of the cities. There are approximately 600 hospitals in the developing countries of the world (excluding Mainland China) with 1,000 or more obstetrical cases annually. Of these, about 150 are in India. Even with the best programs at all hospitals, only about one percent of the women in the reproductive age group could be reached. This is a very crude estimate since it is based on other crude estimates of population of countries and hospitals. Inability to reach all pregnant women is a recognized limitation, and efforts are being made to extend the postpartum concept to the rural areas.

However, even with limitations, the program has been effective in the integration of family planning, I&E and service with a hospital's maternity service. Interest in the concept has been stimulated in other organizations such as the World Health Organization and the Pan American Health Organization. Plans are being implemented by these organizations to extend the program, under a "maternity-centered" designation, to those country programs not now funded by the Population Council. We are encouraged by the interest and activity of these organizations for they, more properly than the Population Council, should be involved in family planning as an extension of good maternal health.

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Panel Discussion

DR. TAYLOR:

Ladies and gentlemen, the final session for this afternoon is in session. The panel is comprised of those who spoke this morning (Mrs. Hutchinson, Mrs. Pilpel, Dr. Rogers and Dr. Shubeck) and two new members, Mr. John Van Miller and Dr. Richard Fontera. Mr. Van Miller is a very recent graduate with honors from the College of Human Biology of the University of Wisconsin-Green Bay. He has a vested interest in the kinds of things which are being discussed here because he has been participating in a research program on the effects of an oral hormonal contraceptive on Vitamin B_6 metabolism. Dr. Richard Fontera holds the appointment of Special Assistant to the Vice Chancellor at the University of Wisconsin-Green Bay. *He is* a political scientist by training and in 1966-67 worked with the Ford Foundation in India in family planning. The administration of family planning programs is his field of special competence. He will also be present tonight as the chairman of the dinner.

Ladies and gentlemen, the panel is ready, do we have a question?

JAN COOMBS (Marshfield Volunteers for Family Planning):

The area that I'm interested in is insurance payments for voluntary sterilization. I wonder if anyone on the panel knows of any concerted individual efforts to encourage insurance companies to offer insurance payments for these kinds of procedures?

MRS. PILPEL:

The Association for Voluntary Sterilization to which I referred this morning has just done a nationwide survey with reference to Medicaid, Blue Cross and Blue Shield reimbursement for voluntary sterilization. I can't possibly sum it up since it's quite extensive. In general, it appears that in many states Medicaid will reimburse for voluntary sterilization for any reason. In most states, or at least a considerable number of states, Medicaid will reimburse only for voluntary sterilization for so-called medical reasons, which includes both physical medicine and psychiatric reasons. Blue Cross and Blue Shield also seem to vary a great deal. The best I can do in answering the question is to suggest that the questioner get in touch directly with the Association whose address I have and and which is in the New York telephone book and ask for a copy of that survey which could be the starting point for following up with some of the private insurance carriers. There's been a lot of work done on this recently because of the question of insurance reimbursement for abortion, which is being widely studied. There is an article on this subject in, I believe, the current issue of "Family Planning Prospectives", which is published by the Center for Family Planning Program Development of Planned Parenthood. That address is 515 Madison Avenue. I think if you got both of those, you'd have a very good start on a more complete answer to your question.

PAT KRAPOHL (Nurse, Marinette, Wisconsin):

I'm interested to know, probably Dr. Shubeck can tell me, are you using paramedical personnel in the foreign countries for insertion of IUD's?

DR. SHUBECK:

Yes, in some countries they will use paramedical personnel. The general rule being that you use the best talent that's available and if you have physicians who can do the IUD insertions and they have the time and are available, that's great. If you don't have that, then you have to train other personnel to do it. My personal experience has been in Barbados where I spent a year in training nurse midwives to insert IUD's and I can tell you that they do every bit as good a job as physicians do.

DR. WENDEL JOHNSON (UWGB):

I would like to know if there are any suggestions from the panel how we in Wisconsin might best attack the problems that we have; one of changing the law that we have on birth control devices and information, and, secondly, how we may resolve our problem on the abortion law. As of now it's essentially in a state of limbo, and if there are any suggestions on either of these, I would appreciate them as would other Wisconsinites.

MRS. PILPEL:

You might get considerable help from the United States Supreme Court because the D.C. case (as I said this morning) will be argued there next Tuesday. If the Court decides that case on what lawyers call the merits, namely on whether or not the D.C. statute is constitutional, and decides that it is not constitutional, your statute and many others may fall with it. If the Court doesn't decide on the merits of that case, it's almost sure to decide on one of the other five cases that are pending before it so it may well be that we will have some sort of an overall United States Supreme Court decision within the next year. In the meantime, I don't think your abortion situation is as bad as your question indicated. That is, unless you know something I don't know because I thought that the three-judge Federal court had now enjoined the Attorney General from enforcing the statute, and although I'd heard rumors that the Court of Appeals in this area - the Seventh Circuit in Chicago - has issued some sort of an order against the three judge District Court, nobody here knows whether that is so and neither do I. In any event, so far on the judicial front, you have done very well with the abortion law in the State of Wisconsin. It wouldn't hurt, of course, if you sought its repeal as a matter of legislative program, but I don't know if there is a chance of that. Even if it is not repealed, you may through your local Federal Court or the Supreme Court in Washington, get relief.

On the birth control front also, you may be helped by the United States Supreme Court because the Federal Court decision holding the Massachusetts statute unconstitutional (which is like yours except a little worse) is also on appeal to the United States Suprement Court. That case will probably be decided within - I say - within the next year, although it's perfectly possible the decision will be sooner. It's also, unfortunately, possible that it will be later, but I think a year is a fairly safe estimate. In addition, however, it may be desirable (and you'd know this better than I would) to mount some case or cases in this State attacking the constitutionality of the birth control law. Since you have had considerable success in what was in a sense a more difficult assignment, namely, attacking the constitutionality of the abortion law, I would think that you would have a reasonably good chance of winning in a Federal Court an attack on the Wisconsin State Birth Control Law. Thus, I believe there are a lot of options open to you.

When it's the turn of the panel to ask questions (I'm just going to say parenthetically), I'm going to ask what the basic opposition is in this State with a view to hearing what can be done besides court cases and legislation, or what can be done to make court cases and legislation more promising.

DR. TAYLOR:

Would you like to ask it now?

MRS. PILPEL:

I really did just ask it. I think we tend to see lines of opposition as clearly drawn, there are those who are for us and those who are against us. Sometimes it is possible by finding out why those against us are against us to change the alignment somewhat. In Massachusetts, for example, the fact that a leading Jesuit priest and educator took a position on the Massachusetts abortion law different from the orthodox Catholic view has had an effect on what's happened in Massachusetts, and I'll just tell you about that for a moment. It all started when Cardinal Cushing made the statement that Dr. Rogers quoted this morning, namely, that Catholics do not need the support of the civil law to enforce their belief with reference to Catholics, and they have no right to force those beliefs on those who don't share them. That was said with reference to birth control. Then the abortion controversy became very active and Father Robert Drinan, who is Dean of the Boston College Law School and was just elected as a member of Congress from his district in Massachusetts, took the position that the Catholic attitude on abortion should be the same. He said that in his view Catholics are bound to object to reform laws because then the law selects which fetuses may be destroyed and which fetuses may not, but that Catholics should support repeal laws on the ground that abortion, like birth control, is a matter of conscience and that peoples' right of privacy entitles them to make their own decisions. The Massachusetts Law on abortion, like the Pennsylvania law on abortion, prohibits only unlawful abortion and doesn't say what that is, which is the kind of things that only lawyers pretend to understand and really don't. The result has been a liberal interpretation of litigation in both states. Although as Dr. Rogers said, the Massachusetts abortion law is bad in the sense that no one knows what it means, I think partly because of the positions taken by Cushing and subsequently by Drinan, there is in Massachusetts, despite its law, a fairly free accessibility to abortion, at least compared to some other states.

But getting back to my question, my question is what groups, besides the obvious Catholic group which presents a special problem, are against those reforms or changes in the law and is it not possible to make common cause with them. It is rumored that in New York common cause was made even with the Catholics on some issues where a give and take was possible. In any event, practical politics and a well thought out strategy can have a considerable impact.

So I now repeat my question and sit down. Who are the forces against you and what kind of approach can be made to them that might put them at least not so much against you or even on your side?

BEA KABLER (Chairman, Wisconsin Citizens for Family Planning):

A five year battle to change this law and I have scars! The opposition, other than the obvious religious opposition which is twofold in Wisconsin - conservative Lutheran and conservative Catholic - is a far-right Birch or "Birchlike" attitude which is expressed in the view that government should not be involved in any of these kinds of things, least of all in someone's bedroom. The position is stated in a bill introduced last session, that no facility, no building, no money, nothing, that has to be supported by State funds should be used in any way to support a birth control program. Those are the three main kinds of opposition.

MRS. PILPEL:

Well, what you just said could be turned back against them completely, and might be a very good basis on which to have a dialogue with them. Maybe you won't win right away on State funds or public funds, but the theory that the State should stay out of the bedroom, and stay out of everything connected with it, should result as it did with Drinan's argument in their permitting the law to be repealed, that this is up to the individual so the State should neither condemn nor encourage it.

BEA KABLER:

And we've answered this by saying that indeed the State is involved already by having such a prohibition. That doesn't sell either. At least not so far.

DR. ROGERS:

Are they proposing that contraceptives should be used every place else but the bedroom; is that their proposition?

BEA KABLER:

They bring up the fact that we have a fornication statute in this State. This gives the legislators who have sworn to uphold the law, an excuse rather than a reason for not being able to support such legislation because it would be in conflict with existing law. There is certainly one group which happens to be both of a religious persuasion and conservative which thinks that birth control should not be used at all, that every sexual act should be open to - you know - whatever may happen - and it does, married or unmarried.

JOHN SHIER (UWGB):

I'm not certain whether this is not a rhetorical question, but I'll ask it anyway. It seems to me that the speakers on the panel and a number of comments from the audience today have been - I will be very frank - hard on Catholics and conservative Lutherans and others of a religious persuasion. I feel that the evidence, at least here in the Green Bay area, is as follows: the papal encyclical on birth control made more good Protestants out of more good Catholics than anything a Pope has ever done, in the sense at least that a great many people who I know and have heard of who are Catholic simply refuse to go along with the Pope's statements about birth control and such things. They reserve this as a right of private consicence. So I'm asking this question: Perhaps in our eagerness to find a source of resistance to the ideas which I believe most of us in this room endorse, it's a little bit too easy to blame the Catholics and other religious folk generally, whereas, we're really dealing with attitudes that have a much deeper root in the consciousness of the people who are in opposition to liberalization of abortion, to the greater availability of contraception, to the very idea of family planning. Would anybody on the panel comment on this please?

MRS. HUTCHINSON:

I would agree with you. My community of Buffalo is quite similar to yours in that we have a high Catholic population. The majority of our patients are Catholics. We have numerous Catholics on our staff. My agency is having a Catholic priest next Thursday to open our annual fund raising drive. He is a Jesuit priest; a member of the National Planned Parenthood-World Population Board of Directors and very much in our corner. I have supplied a Catholic nun in Brazil with Spanish literature. She runs two family planning clinics in Brazil and is funded by the Brazilian government and the Catholic Church of Brazil. I think things are changing and I believe, and I hope Dr. Rogers will back me up on this, that the national surveys say that the majority of Catholics in the United States are not opposed to birth control.

DR. ROGERS:

I don't know whether that's correct and actually I don't really care, because I feel very strongly as I thought I stressed at the beginning of my talk this morning that both those who are opposed to contraception or abortion, or those who are in favor of these two things, in my opinion, are each entitled to their own opinion and to follow the dictates of their own conscience. I'm not the least bit interested in overcoming Catholic opposition to either of these things. I am very interested in seeing that people who wish these two things have access to them and I do not like the idea of blaming the Catholics, although I think in some ways they have been to blame for some of the restrictive laws. But I'm not out to sell abortion or to sell contraception. I want people who wish these things to be able to get them without going through a great deal of red tape.

DR. TAYLOR:

Dr. Pilpel?

MRS. PILPEL:

I love being called "doctor" and have recently become entitled because all the Columbia law degrees can be changed from bachelor to doctor if you pay $25 and I did. But nobody calls us "doctor" anyway except very nice people occasionally like you - it makes us feel good.

On the Catholic issue, I thought of a few points in addition to agreeing with everything Mrs. Hutchinson and Dr. Rogers said. The Catholic priest she referred to does come from Rochester. He's one of the most active and influential members on the National Planned Parenthood Board. When I spoke in San Antonio a couple of years ago, I found that the local chairman there was also a Catholic. I know that studies have been done at the Margaret Sanger Bureau in New York which have indicated that the proportion of Catholic patients at the Bureau are the same as the proportion of Catholics in the population. In other words, if there are thirty percent Catholics in the population, then the patient load will be at least thirty percent Catholic. I mentioned this a few weeks ago to Dr. Edris Rice-Wray who was in charge of the (I can't pronounce Spanish very well) Association Pro Salude Maternal in Mexico City and she sent me three pages of comments from their patients in Mexico City. Virtually their entire patient load is Catholic and I had asked whether that did not keep them away or make them less willing to use contraceptives.

I don't want to take the time to read these comments, but some of the statements from these patients are rather interesting. One girl, for example, said "I believe everything, but I don't believe they should stop me from taking my pills. When I went to confession the priest bawled me out for taking the treatment and I got furious. Since the Church won't help me I talked to my husband about it and confessed to him. And he told me do whatever you can to solve this problem; don't you think we have enough troubles as it is." Another woman said "I would like to use rhythm but don't understand it. My neighbor uses it and she already has two daughters. I confessed and the Father would not forgive me for using the pills. I told him that for me it was much more of a sin to have an abortion or have my children before time so that they die soon after birth. The priests say no to birth control because they don't care when the children die. I think what I am doing is right."

Now, I suspect this does reflect the opinion of probably more people who are Catholic communicants than anybody has any idea of. And I agree with you, Walt, that I don't want to persuade the Catholics for themselves. The only thing is that in Latin American countries, for example, and other countries where they are in a dominant position they prevent the state from making the services available and if the state doesn't make the services available in those countries, services are not available. Isn't that true?

DR. ROGERS:

Well, yes and no, in the two Latin American countries with which I am somewhat familiar. It is true that the state doesn't make either abortion or contraception available. On the other hand, there are many, many priests in small poor communities who are very actively, although very quietly, engaged in helping their parishioners to obtain these services. And it is unfortunate, in my opinion, that the state doesn't make them available, but people do avail themselves of sometimes primitive and harmful means of both contraception and abortion, but they certainly avail themselves of it. The primary reason for hospitalization of women in both Nicaragua and Columbia is for complications of abortion. There are more women admitted for this cause than for child birth.

DR. SHUBECK:

May I make a comment about this. Some of the countries in Latin America, you may have familiarity with only two, but maybe as a result of the S.S. Hope being in Cartagena, that's one of the two hospitals in Columbia that's increased the number of sterilization operations. But Columbia has almost an official government stand on family planning, it is being promoted throughout the entire country. Venezuela is increasing its activities rather largely. Costa Rica is going to have an official government policy for family planning. There is lots of activity going on in Panama. The country of Honduras is going to have a national program. Most of the countries in which I visited throughout that area are either on the verge, or are going to have a national policy for family planning, or are willing to accept a family planning stand which does not officially involve the government but will permit promotion of family planning throughout the country.

DR. ROGERS:

I would like to comment on that if I may. That is correct about Cartegena. As a matter of fact, I know the professor of Ob.-Gyn., he is a good friend of mine and he was in New York City last summer learning new techniques of sterilization. But aside from the government programs which you mention, many physicians quietly on their own give contraceptive advice even though it may be against the official policy of the country.

DR. FONTERA:

It seems to me that the last, with all due respect, the last comments remind me of a childhood spent in New York subways where it said that you didn't have to be Jewish to eat Levy's Rye Bread and I guess you don't have to be liberal Protestant to like enovid. It seems to me that underlying Mr. Shier's comment and several others is a question of matching paces of social need to attitudinal change. Essentially we're very close here to the whole problem of whether you approach it from the social need. There are too many people clogging resources, creating a variety of problems from crowded highways to difficulties with educational facilities, etc., and something needs to be done from that point of view - the population bomb point of view.

And then I think you get very close in this area of the country to the difference between the facts about population growth and the perceptions of population growth. Brown County, with an enormous population growth statistic, is perceived by its inhabitants here as being an underpopulated area. Hence the folk wisdom, family planning is needed in Caracas, Venezuela, because the "Christian Science Monitor" and other newspapers run pictures showing that there are too many people there. There aren't too many people in Green Bay, Wisconsin, except at the football stadium on given occasions. Equally, if you approach it from the personal rights point of view, you are then a little bit slaughtered by the difference between law and prescription and individual, particularly middle class, behavior. If movements in favor of the liberalization of laws are perceived as led and financed by essentially higher educated, middle class, etc. people, these are the people who can solve the problem now. The fornication law in this State does not seem to affect, overly, people in the upper and upper middle classes, nor does the anti-abortion statutes; contraceptive difficulties don't affect these people nearly as much as it affects people of a quite different economic group. And in this City a vasectomy is running, I am told, something in the neighborhood of $350, and this is a City without a public health clinic of any sort whatsoever, and I think a movement in favor of such a clinic would have to run against the attitude, which is really my point, that public health clinics are needed in New York City, in Chicago, and Boston and St. Louis and Los Angeles, where there are too many people, and not in Brown County, Wisconsin, where the population rate is much higher than that.

Now, before in the paper presentation, I was struck again, where does, if I may ask a question, where does the coming together of the issue of a hospital model centered community program come to grips with large areas of the world in which the rural population runs up above eighty-five per cent? And where even in the City, my experience is Indian but it applies elsewhere, even in the City the class of people who go to hospitals for birth purposes is really very narrow and small. And where what in India is called the Di, and elsewhere was called the midwife, different terms, you made a reference to Africa, is the person somebody sees and you have a premedical frame of attitude and mind. People who have never gone to physicians for anything, women who have never had an internal examination of any kind were being asked primarily to put their trust and hope in the wonders of Boston-Harvard technology in the form of the plastic extruded loop. And one of the findings as to why the program wasn't making it was because it asked for an attitude towards medicine and towards the human body which was not present in any numbers of significance in India at all.

DR. SHUBECK:

Well, there's lots to this. The postpartum program, or postpartum concept actually, was started only as a demonstration program and obviously was an urban program because that's where the hospitals were. And we recognize that in some countries as much as eighty per cent of the country may be rural and people don't have access to hospitals. There are lots of other problems associated with trying to reach the rural people rather than to have them simply come to hospitals. But there is a program that's being designed and probably will get implemented at least to some extent probably in 1971, called the Taylor-Barrelson Project, and this is a means of trying to extend the postpartum concept to all of the women in the developing countries in the world, whether they be urban or rural. The concept simply is one of trying to see that a trained individual is available for each woman who may be pregnant, so that each woman who is pregnant will have at least one or two visits by such a trained individual, and that she will have a better facility for pregnancy care and delivery and that this program also be part and parcel of family planning for spacing or limitation of family size.

DR. TAYLOR:

That was quite a question you asked Mrs. Pilpel. I would like to ask the indulgence of the panel now to throw the matter open to the audience once again.

JOYCE HALRON (Marshfield Volunteers for Family Planning):

I have one answer for Mrs. Pilpel's question in that our main far right opposition is through the John Birch Society with their movement to restore decency. Besides their objection to government intervention in private lives, their other main objective in getting to the people is on the morality issue. And this is one of the - you asked what our opposition was and it is a morality issue in asking - they don't want any liberalization of either of the abortion laws or the contraception laws on this issue.

DR. TAYLOR:

Thank you. Oh, there are hands all over the place now. There was someone just about in this corner earlier on.

LEE REED (Green Bay):

I can't resist in response to the question and some of the discussion that has gone on since the question was asked, quoting that well-known philosopher Pogo "We have met the enemy and they is us". Now, I'd like to ask a question. Has any woman living in a state whether the court, or the legislature, has said it is her right, her constitutional right, to an abortion before quickening, brought suit against any physician or hospital or agency for not having provided this abortion?

MRS. PILPEL:

There are a number of cases scattered throughout the United States where actions have been brought by pregnant women to force hospitals or doctors to give them abortions. The problem is that sometimes those cases become moot before they get very far in the judicial machinery. It's often too late for the plaintiff woman to have an abortion by the time the case is heard. In New York, where we started such a case on behalf of doctors and various women's and civil liberties groups started related cases for pregnant and other women, they had this kind of problem and it got to be a somewhat complicated situation. Actually, it is easier to pose the question through the doctors who, in the Griswold case, the United States Supreme Court said had a right to raise the question as to their patients.

Now as to women who were denied abortions, we had a very tragic case in New York which I hope we will be able to do something about. A woman went to a doctor who thought that she had had German measles when she was two and one-half months pregnant. He sent her to the hospital; she was examined and interrogated by several doctors and certified for an abortion. As she was wheeled into the amphitheater for the abortion, the head of the service countermanded the instruction for the abortion and she was told in effect "You don't need an abortion - everything is going to be all right - now just you go home and have your baby and don't worry". So she did go home and have her baby. The baby is a hopeless cripple. This woman did bring suit against the hospital and from a Brooklyn jury, predominantly Catholic, she got an award of $100,000 for the child and $10,000 for herself. A motion was made by the hospital to set aside both verdicts, and after some months of deliberation, the verdict as to the child was set aside on the ground that no one has a constitutional right not to be born. You really have to be a lawyer to understand why that should have been the grounds, but it was. Then the hospital appealed the $10,000 judgment for the woman to the next higher state court which set it aside on the ground that the abortion would not have been legal in New York State. So they got nothing. That case is now pending on appeal to the highest court of the state, and if funds and support can be found, it will be heard there. It's the tragedy of these cases that it does cost money to go through the courts and that the women who are most likely to be adversely affected don't have it. But civil liberties groups, women's lib groups, the Association for the Study of Abortion and Planned Parenthood are interested in this case. There's been no dearth of cases brought by pregnant women so in that sense the enemy is not us.

DR. ANDREW KRAPOHL (Physician, Marinette, Wisconsin):

In communities where the Catholic hospital is the only hospital in the community, and, of course, most of these hospitals have rulings or philosophies about not doing sterilizations, what could happen if a physician did a sterilization? Do the hospitals have any stand where they are a private institution, but furnishing the community resources for that community?

MRS. PILPEL:

There are two kinds of answers to that question. When you say "What could the hospital do", it's like saying "Can They do this to me?" - you know if it's done it's done. I suppose they could suspend the doctor or deny him privileges as a practical matter. Now as a legal matter, that was done by Catholic hospitals some years ago with reference to doctors on their staff who refused to agree as a condition for their continuance on the staff that they would not prescribe birth control even in their private practice. They were thrown out of the hospitals and denied the right to practice there.

In one community the Catholic hospital was the chief health facility in the community. Cases were threatened in those communities, but they were not necessary because the community was so aroused. The Planned Parenthood forces did a good job on information, education and communication and their hospital privileges were restored to the doctors. I don't know of any doctors who have been suspended or denied privileges by reason of having done sterilizations in a hospital. But there is an increasing awareness on the part of the people who have studied the legal aspects of this field that every hospital that has tax exemption, or receives public funds is to some extent a public institution. Last week a court held that there was a right on the part of recipients of medical assistance to bring suit against a hospital which is financed by federal funds under the Hill-Burton Act because that hospital was not giving adequate medical service. And the court held that who better than the patients had the right to sue the hospital which was being financed with public monies to perform a public service.

I believe that the case which is now pending in Salem, Oregon, together with other cases which are going to be mounted within the next year will seek to establish the principle that where a hospital is tax exempt or where it received public funds, or both, it cannot practice sectarian medicine. Now that's not going to be an easy fight to win, but I think it's a fight that is now overdue and I feel that if we are able to surmount the procedural obstacles that technical lawyers will throw in the way, we ought to be able to get a decision that a community health facility has an obligation to serve the community without regard to the religious beliefs of the group operating the facility. Now that doesn't mean that individuals should violate their consicences by doing something themselves, but it means that the facility which is being supported by the public must make alternatives available if their own staff people are unwilling to give a service which the people in that community need and want.

DR. KRAPOHL:

Yes, this perhaps isn't necessary, but what would happen if a group in a community mailed to everyone in the community information about contraception. Is there anything legally against doing that?

MRS. PILPEL:

Well, you're in Wisconsin - I mean that's your problem. The federal law which might have had something to do with it if we hadn't more or less succeeded in getting it interpreted out of existence, might have stood in the way, at least in the minds of anyone who read the law, until the so-called Comstock Laws were repealed. If, as I believe, the President has now signed the repeal, and I believe they no longer exist, and the only thing they now prohibit is the sending of unsolicited contraceptive material. Your question does contemplate that possibility. I personally believe that there is a constitutionally protected right of freedom of the press which includes the right to circulate all information except perhaps where there is a compelling necessity to prohibit it to avoid some evil, which I don't think knowledge about family planning in and of itself could possibly cause. So I think we would have very little difficulty with the federal law. However, the state law provides that no person, firm or corporation shall publish, circulate or distribute any circular, card, advertisement or notice of any kind offering or advertising any indecent article - contraceptives are for this purpose apparently indecent articles - for sale, nor shall exhibit or display any indecent article. That kind of statute has been interpreted in both California and Arizona not to apply to notices or advertisements referring to medical care. Now, I'm not sure about your question. If you're talking about sending contraceptive information only, not accompanied by supplies, the Wisconsin law might not apply. If you're talking about writing to people and saying the things that Mrs. Hutchinson mentioned - you don't need to be pregnant and if you don't want to be pregnant, just consult the doctor at the family planning center of your local hospital or something to that effect, I don't believe (a) that the law would be applied to that, and (b) I'm virtually sure (which is dangerous for a lawyer to say) that it would be declared unconstitutional as a violation of freedom of the press if it were so applied.

PAUL DRESEN (Graduate (biology) Lawrence University, Member ZPG):

I'd just like to make a couple of comments in reference to the supposed stands taken by the John Birchers and people similar to their thinking in Wisconsin. It was noted that they are against support of the birth control and contraceptive clinics because these would be state funded. And in answer to this, I would just like to direct to them the question: how do they feel about the mental health facilities which are necessary for the health of women who are forced to carry through.

DR. FONTERA:

They are opposed to it. The Birch Society has a very interesting pamphlet which opponents to the Birch Society have suggested is a form of self protection, which may be overly cynical, attacking all mental health programs as essentially a form of brainwashing.

PAUL DRESEN:

And what about the illegitimate children and juvenile delinquency which probably results to a large degree out of unwanted pregnancies.

DR. FONTERA:

I'm not a member of the Society, but they would say that that is a result of parental permissiveness.

PAUL DRESEN:

They also are against the immorality which supposedly arises out of premarital sex and abortion and contraception.

DR. FONTERA:

"By your fruit shall ye know them".

PAUL DRESEN:

I guess that pretty well answers all my questions. There's no way of getting around them.

DR. FONTERA:

No, quite seriously,that's a very locked kind of argument. I truly feel that if you relate all of this to social betterment, reform movements that there is a time when one is engaged in these in which one just has to freely admit no matter how liberal and fair minded one is that there are groups in every society that are not going to convert to one's point of view. I think that it's quite accurate to say that on the one hand you seek the allies you have, or can have, being reasonably scrupulous about it, and on the other hand that you recognize that you're going to have some opponents. I mean we shouldn't sit here and believe that at this conference we are proving by our own numbers that there are no significant elements within this State, or any other state, or in the country as a whole, who are opposed to - let alone the things we are talking about - who are opposed to things that are already legal to do, including convening such a conference. And that we're just going to have to leave such people to their confusions and hope that they, too, will be saved by us. I mean you have to sort of take the attitude of the missionary who says "Well, at least the headhunter confessed at the end".

JOAN DRAPER (Population Institute, Washington, D.C.):

I have two questions, one for Mrs. Pilpel. How much money has been appropriated for contraceptive research and services as a result of the Tydings' Bill which passed? And two, I would like any of the members of the panel to respond from their perspective as to how they think students can get involved and act around the issues of population, birth control, sterilization, abortion.

MRS. PILPEL:

As near as I have been able to find out, since you asked me that question this morning, there is no definite appropriation as yet under the Tydings' Bill. I'm reading from a release from the Washington office of Planned Parenthood: "Senator Tydings appeared December 4 before the Senate Appropriations Subcommittee to request twelve million dollars each for services and for research to begin the implementation of the Tydings Bill which has now passed. This was his second attempt to secure additional funds for fiscal 1971. The first to amend the main Senate appropriation bill floundered when the administration indicated that the funds were not needed and would not be used if appropriated (which must have been very helpful). The administration relented in its opposition to additional funds for services, but not additional research funds. Then the Subcommittee of the Senate did allocate the twelve million dollars requested for services and five million dollars for research. In conference with the House Committee, however, Senator Robert Byrd, Chairman of the Senate Subcommittee, could not prevail over the opposition of the chairman of the House Subcommittee, Daniel J. Flood of Pennsylvania, and, therefore, at the moment there has been no, as far as I can see, special funds appropriated for the Tydings Bill. Perhaps some of you here who are more aware of what's going on in Washington know what will happen when the new Congress convenes. It is my impression that they will appropriate something like twelve million additional dollars for services which, of course, is rather small compared to thirty billion dollars for our military establishment. But twelve million dollars for services and at least five million dollars for research seems to be likely, although I can't give you any definite assurances or figures.

DR. TAYLOR:

There's another question, what can students do, would any member of the panel like to address himself to that one.

MRS. HUTCHINSON:

The students are thinking of ways themselves; they're much more innovative than some of us could ever be. Students, it seems to me, are doing all sorts of things all over the country. In Miami, they are raffling off contraceptive devices and giving the money to ZPG. They made a movie at Kansas State; they're running surveys; they're writing their own birth control manuals. At one of the colleges, the students went on a three month hunger strike - one student a day went without food. The money that would have been spent to feed them went into family planning. You know, I couldn't dream these things up, they're great. They sit in little boxes and add more people every day to show you what the crowding is going to be like in so many years. I think the greatest incentive for establishing contraceptive clinics on campus has come from students who have very calmly and intelligently approached the administration and the student health services. They've explained why they need contraceptive care (there's been no rocks thrown), they've been well informed and, as a result, there are more and more on-campus clinics popping up. I think students are doing a marvelous job. Perhaps, it's just a matter of making more material available to them to help them.

JOHN VAN MILLER:

It seems to me that the problem with the students is to get enough of them active. Even at an university such as UWGB, we still find a conservative group of students wanting three or more children. It seems that not only do we have to have a community outreach by the student population, but also a little homework, if you will, that they have to reach the other students as well. And I think we've seen many examples around the country of the constructive things students can do when they join together (a lot of destructive things too, unfortunately). But the problem now is to get a lot of support for the population programs such as Zero Population Growth.

MRS. HUTCHINSON:

I think too that it behooves family planning agencies to include students on their boards, on their committees, and as volunteers. Students are great for this. We use them in Buffalo on our Information and Education Committee and our Community Relations Committee. They are certainly an important segment of the community if we want to reach the young, and we do! I use student volunteers too. They work very hard, are very conscientious and terribly interested. I think we should make sure we include them and not just assume that they won't be interested or won't work for us.

DR. ROGERS:

I'd like to get in on this for just a minute if I may, Dr. Taylor. I don't know whether this is a sensible suggestion or not, but it occurs to me that fornication doesn't always start just after the reception of the high school diploma. As a matter of fact, there is an eleven year old girl in Providence wearing one of Dr. Hugh Davis' IUD's. I wonder whether college students could be of some help in educating kids in high school and junior high school in voluntary groups. It seems to me that college students would be ideally suited to do some of this work and I think that contraceptive information ought to be available to all kids as soon as they reach reproductive age.

DR. JEREMY GREEN (Physician, Green Bay):

This perhaps I can best direct to Mrs. Hutchinson and perhaps John Van Miller. One of the problems that I have faced when I discuss contraception and birth control devices here in Green Bay - this is perhaps a question of attitude particularly to teenagers - the question of giving contraceptive devices to teenagers, is a possible increase in promiscuity and venereal disease because of these devices. Now, as I understand it in Sweden, this has not been shown to happen that there's increased promiscuity among teenagers or venereal disease. But certainly, perhaps even more so, venereal disease, which is a health problem - I am wondering if any members of the panel, particularly these two I mentioned, might be able to comment, or do they have any figures on perhaps the increase in promiscuity or venereal disease because of birth control devices being given to teenagers, college students, unmarried women?

MRS. HUTCHINSON:

I think we're very remiss in our education of youth if we don't teach about venereal disease. This is an important part of the whole sex education thing. I think when young people are educated about venereal disease, we'll see lower statistics on it. There are studies that indicate that when young people have received good sex education - and I emphasize the good because we all know there is some terrible sex education, or something going on under the guise of sex education - when good sex education is available for the young, that they do act in a more responsible, sensible way. We always get this question about promiscuity. Promiscuity is with us. Look at the illegitimacy rate. Those women and girls don't have contraception. One of the things we can do to counteract our illegitimacy rate is to get these young women contraception. This buys time to help them, perhaps, not to be promiscuous. I don't think you're ever going to solve the illegitimacy problem or the VD problem until you educate.

Incidentally, the rapid rise in the VD rate is from 12 to 20 years of age. We are now asked to do contraceptive orientations by social work agencies who work with twelve year olds who are sexually active. They know nothing about contraception. They are already sexually active. We did not make them that way by educating them. We are simply trying to, again, buy time until someone can work with them.

JOHN VAN MILLER:

I have to agree with Mrs. Hutchinson completely that the whole thing comes down to sex education. But it seems to be, basing my view on knowledge gained from the people I know and the people I've talked to and the people they know, that promiscuity is with us, that it -

MRS. HUTCHINSON:

Has always been with us.

JOHN VAN MILLER:

Yes, but I think it's increasing now for very many reasons, and that actually the making available of contraceptive devices to people before marriage is possibly an advantage because of the fact that then at least we are giving them something to go with. I think it's a necessary program to institute and I don't think that the rise of promiscuity will be as great as a lot of people think it is.

MRS. HUTCHINSON:

About this great debate on whether promiscuity is on the rise or not. Perhaps we're able to talk about it more. Perhaps we are more aware of it. I question whether it really is on the rise and I do feel that many young people are acting more responsibly now. In fact, many of the college youths are acting like old marrieds. They're not running around. They're down to a one to one responsible relationship. I'm not sure that this isn't better than what we had before with people just running around and being sexually active sort of indiscriminantly. It seems to me that we are beginning to see something that looks more responsible. Would you agree?

MRS. PILPEL:

I hate to be Johnny One Note, but I don't think that we're going to get very far with our program of serving teenagers or college students if we don't remove the laws which are giving medical personnel reason to be apprehensive if they do anything in this field. They are afraid that they may be sued by somebody. I do regard it as encouraging that over thirty states have now ameliorated their laws in some ways, but I'm puzzled by the fact that there is not more push behind their further modification. As a practical matter, unless you are planning to give teenagers and college students non-prescription contraceptives you may find not only the doctors in their private practice worried, but also that many of the clinic doctors who are involved in a program of family planning are also nervous in terms of their malpractice insurance. So I think one of the aims of a group like this should be to spread the word that the law must make clearly possible medical services to teenagers at least in the family planning and pregnancy related areas without the need of obtaining parental consent.

The only study I can recall offhand of the relationship between promiscuity and contraceptive availability is the Kinsey study which tended to show there was no connection between them at all. Now I realize it's terribly old even to mention Kinsey anymore, but I'm not sure that there have been more recent studies which in any way contradict that study which appears in the Woman Volume. I agree with Mrs. Hutchinson that if promiscuity means sexual relations on a casual basis with a lot of people, from where I sit and what I've heard that is not happening. Instead, there seems to be coming into being what is almost a new form of marriage. It doesn't happen in many instances to be sanctified, if that's the right word, by either the clergy or the state, but young people do live together and have sex relations on a one to one basis in a very responsible manner and if that is typical, which I agree with her at least in my experience and from what I know it is, then there is less promiscuity.

But to give you an idea of what the law can do to mess up this whole program, I'd like to just take a minute to tell you about a case which arose in Cleveland, Ohio a few years ago. A young black girl had her first baby at twleve and her second baby at thirteen. Her mother dispaired of ever being able to keep her non-pregnant, and said to her "You must not be with boys and if you go out with them, you have to be home by eight" (which, incidentally, she always was), "and, in addition, you must be sure the boy uses something, do you know what I mean?" And the girl answered, "yes, you mean rubbers". The girl continued to go out, getting home at eight, but her mother became so unhappy that she had the child become a ward of the court. She was placed on probation on condition she not become pregnant again. Of course, the court did nothing about family planning information. And, of course, she did become pregnant again with her third child, whereupon her probation was violated and she and her mother came to court. Her mother told her story along the lines I just told you including the part about how she had told her child that the boy should use rubbers. At that point, the judge commanded the bailiff to arrest the mother for impairing the morals and contributing to the delinquency of her minor daughter by mentioning contraceptives to her. The woman was tried, convicted and sentenced, and her daughter's other children whom she had been taking care of, were taken away from her, and so forth. At that point virtually every public interest group in Cleveland got interested - the humanists, the Planned Parenthood group, the civil liberties group, the legal aid group and so forth - and they carried the case to the Supreme Court of Ohio which reversed that conviction and held that the statute as thus applied was unconstitutional on the ground that it interfered with the mother's freedom of speech. Now, I am in favor of winning a case on any theory, but it seemed to me that the court was straining pretty hard to reach a result which every common sense person would have reached in the first place. Since then, the Ohio law in this respect has been changed. But many of the supposed laws on minors have not been changed and I would hope that those of you who are active in the family planning field would keep your eyes on that problem. While it may not be worth fighting for, if it means you're not going to win a repeal of the contraception law or the abortion law, in many instances it's just as easy to try for two or three things as for one. In New York we found it was easier to get complete repeal of our abortion law than to get lesser reforms. So I hope this particular problem about minors will not be forgotten.

MRS. HUTCHINSON:

Mrs. Pilpel, I would like to ask you a question. In New York State we've recently had the law changed so that minors could be tested and treated for venereal disease without parental permission. This seems to me an awfully good kind of legislation to push for. I'm wondering how many other states have this?

MRS. PILPEL:

Well, it's awfully good legislation in New York as far as it goes, but it only goes as far as venereal disease. In New York State it is not by any means clear that doctors can prescribe for teenagers for contraception and abortion also. We have written a lengthy memorandum of law to the effect that they can. Attorneys for the Voluntary Hospital Associations, both city and state, have written similar memoranda coming to the same conclusion, namely, that there are many cases of minors who can be prescribed for without parental consent. And the Health Services Department of the City of New York has said that any person seventeen or over can get an abortion without parental consent, and under seventeen where, in the opinion of the physician, the obtaining of parental consent would present a health danger. Thus, there is a great deal of liberality possible under the New York law. I don't mean to always be criticizing the medical profession (and it's always easy to be very courageous at the expense of somebody else, I wouldn't be losing my insurance, but they might) but I do think they are unnecessarily concerned. However, while I am pretty much convinced that no doctor would be held liable if he treated a minor in most circumstances, I'm not clear you can persuade the doctors that is the case unless you pass a specific enabling law like the New York VD law.

KAREN LEPIANKA (UWGB student):

Returning to the sex education question, I was very interested in it and I went back to my high school and this is a problem. I think it is true around this community also. Sex education courses are not taught as such and students, as I am, go back and talk to the principal and find that the courses are hidden. They may have a population course that may be taught in geography, or something like this. But none of the courses are correlated as to teach the students anything about sex, or to prepare them for when they do graduate and are out in the world. I think this is the reason you have so many naive people graduating from high school. We don't have, in this area, any established sex education courses.

MRS. PILPEL:

I agree with you and I find the situation in a way worse even than what you said. Last year Dr. Guttmacher and I were invited to address the social work schools in the City of Philadelphia - three major social work schools. Dr. Guttmacher started his remarks by saying to the student bodies of the three schools, "Will those who have had the subject of family planning discussed in any course of their curriculum, please raise their hands". Not one hand was raised, and these were social work schools.

DR. POHLMAN:

I just want to comment on Dr. Green's question. As I understood his question, he wanted to know whether we have any research to show a relationship between the availability of contraception and abortion and sexual behavior outside of wedlock. Now, my reading of most of the comments that followed (purportedly) in answer to this is that they did not bear on it the one thing that I've seen sighted that's sort of peripheral to it is the study by Michael Sonenfield of young people in London, called "The Sexual Behavior of Young People". He compared young people who were sexually active and those who were not. He found that those who were sexually active were more afraid of pregnancy than those who were not. From that he drew what I see, or at least some people have drawn, a rather stupid, in my view, conclusion as to cause and effect. And that was that he had proven that fear of pregnancy does not keep you from having sex relations. I think that's not the question Dr. Green asked. And I don't want to be branded as a conservative in this liberal group, for I certainly am not; I have very liberal biases and I want to see contraceptives and abortion made more available to people who are sexually active outside of wedlock. And yet I do think that the question remains an open one whether particularly in a historical sequence, from a research point of view of correlation of what's going on doesn't prove causation. Even if you proved causation at a particular time in history, you haven't proved what's happening sequentially, historically. And I'm still not certain but what it may be that historically the availability of abortion will tend to make people have some greater willingness to participate in sex out of wedlock. This is only a speculation that it's possible, I'm not suggesting that it is. But I'm suggesting that to my knowledge there is utterly no research to show one way or another whether this is the case or not, and I'd be very happy if others could correct me on this.

DR. PONTERA:

I can't say that there is research on the question of the availability of contraception related to the amount of sexual activity, but I think there are now research dealing with prohibitions, not the least of which is the vast amount of research on the question of the prohibition of alcohol. And the introduction, then, of conditions where alcohol could be freely gotten and the relationship of that to drunkenness. Now I realize by using that analogy I'm making certain assumptions I wouldn't otherwise defend about promiscuity and contraception, but I think that in examining those some of the more interesting findings, to me at least, is the relationship between drunkenness, if that's alcoholic promiscuity, and the existence of prohibition. There's enough of that evidence, even on the practical level, so that political studies of votes of going dry and wet have shown pretty conclusively that in the last twenty years in places that have local option, one of the ways in which the drys, that is the people opposed to having alcohol, or alcohol by the drink, which is also an issue, have received a good deal of their funding from bootleggers. This is perfectly logical since bootlegging is not possible where liquor is free and abundant. There's a national study to that effect. There's a couple of studies in Oklahoma, etc. Now I think on the other hand, we could pile this room full of studies to prove either end of that question, and I doubt that the broad public effect of attitudes in terms of being for and against given kinds of legislation would be affected very much at all. What I have in mind is that here you get very close to a kind of cause and effect in "moral behavior" and I know that Dr. Pohlman knows, but others may not be familiar with the fact, that in the Indian family planning program when finally some sociologists and psychologists were actually allowed to go along with physicians and look at some of it, one of the things that they ran into was that in Indian rural life, there is an assumption that women can't help it and men can. Which is, by the way, 180 degrees away from some of the lay assumptions of western, at least North American, life, namely, that men can't help it and women can.

So that as a result of this you've found some opposition - some strong opposition - to the introduction of contraceptive devices which involves female usage because of the assumption that if that was introduced, with pregnancy being the hold against extramarital sexual behavior, that would be removed and women who couldn't help themselves would be winked at near the village well by some stray male and the obvious promiscuity would result. I truly believe that if you introduced fantastic studies to rural India and explained it to everybody that there was no relationship between the two, it wouldn't change the belief structure one bit. And I think much that we've discussed is really, for me at least, involved in the difference between the change rates - between the change rates of technology and the change rates of attitude. The technology is now available. Within this decade it was assumed in some foreign programs that the technology being available would cure the problem.

I remember on my arrival in India being lectured at by a Ford Foundation physician who opened his presentation on family planning in India by saying "Family planning problems in India have been cured". He then looked up and described for twenty-five minutes the loop and all of its joys, pointed out that the Kaupur factory had just opened at, I think, a production rate of a million loops per month. And a year later I did a survey on the use of loops by workers in the loop factory in Kaupur. One Hundred twenty workers and their wives - there were largely ladies - it turned out that one hundred nineteen people were not using loops and one male who had his wife using the loop was sixty-one years old. Now they had a factory. I don't know if Dr. Pohlman's been there, I suspect he has ; the factory is plastered with posters saying "A Small Family is a Happy Family". Most of the labor consisted of placing the string portion of the loop - they were handling loops all day long; they obviously have some sense of what they were for. And the questioning as to why the loop wasn't being employed showed the answers were really very simple - children are social security.

When I'd raised that point a half year before with the physician involved from the Ford Foundation, he called that sociological nonsense. If it's sociological nonsense, it's very widely believed. And I suspect that if it's sociological and psychological and economic, or what have you nonsense, that promiscuity is related to the introduction of contraceptions, it will still be widely believed. Until we get at things I think even further than the question of a sex education curriculum, even as an educator, I see no proof that values are automatically changed by good textbook assignment.

LEONARD WEIS (Appleton):

We've heard from Mrs. Hutchinson that perhaps a new social institution or placing - or maybe it was Mrs. Pilpel, the society's approved wedlock is growing up, and yet Dr. Pohlman referred to increased sexual activity out of wedlock. I would like to ask Dr. Pilpel whether common-law marriage is still recognized in this country. I have the recollection as a boy that if a couple live together for as long, I think it was ten years, this was recognized as a marriage, even if there have been no legal documents signed. Wouldn't this be the same kind of thing again?

MRS. PILPEL:

I believe that common law marriage may still be recognized in a very few states of the United States. It is most definitely not recognized in New York, or any other state where I have looked it up. What I was talking about really was not a common-law marriage even if common-law marriages were recognized, because common-law marriages were recognized on a basis of people giving themselves out as being married, as being husband and wife. In the kind of union I was talking about young people definitely do not give themselves out to be husband and wife. So I wouldn't think whether there was common law marriage would make any difference. I myself feel that a judge that most of you have probably never heard of, named Ben Lindsay, may have had a good idea. He talked about companionate marriage many years ago. It was his proposal, as I recall it, that people should live together on a tentative basis from which it would be very easy to disentangle themselves with no lingering obligations like alimony or anything so long as they remained childless. If they became parents, then their status automatically shifted; certain requirements and obligations come into being, and they became husband and wife in the usual sense. I have a feeling that what we're witnessing among young people in many parts of the country and on many campuses is this kind of companionate marriage and it might be a good idea for the law to recognize it.

TED BURNS (Science Teacher, Green Bay):

Margaret Mead has proposed a suggestion, I don't know if it's been discussed before, but Margaret Mead has proposed a suggestion to cut down the divorce rate, particularly in certain social and economic levels. What is the panel's opinion on her suggestion that maybe we should have a moratorium on marriage and until the two people are sure that they are compatible and thereby alleviating possible divorce.

MRS. HUTCHINSON:

As I understand Margaret Mead's proposal, and I may not be completely up to date on this, she proposed two kinds of legal marriages. One that was easy to get into and easy to get out of, but there were no children involved in this marriage ever. The other one was hard to get into, hard to get out of (perhaps was the second stage of couples) and did involve children. And if that's what you mean, I think it's a great idea. I think that's what we have in a way, or, perhaps, what we're moving towards with the young people coupling off the way they are. Sometimes they do go on and get formally married.

DR. ROGERS:

I agree.

MRS. KRAPOHL:

I would just like to say that we've talked a lot about education. A lot depends on the caliber of people you have teaching it and their attitudes. How to screen these people - I don't know. Being a teacher of expectant parents' classes - Dr. Shubeck mentioned catching the mother right after she had been through labor and delivery when she was a prime target - I feel it is a good time to insert the IUD and such because many of these people might not return for a six-week checkup. I believe strongly that expectant parents should be taught that pregnancy is just a minor part of total family living and that much will be gained if you can involve them in this thinking when we have them in these classes. I know we are just beginning in Wisconsin to have expectant parents' classes. I have already incorporated contraceptive information in my expectant parents' classes where the mechanisms are shown. We show and explain the methods, but I am fortunate because I teach in Michigan and so am not bound by Wisconsin's law against showing pornographic literature. And it's amazing; I have never had anyone get up and leave my class because I am talking about contraception. Now, I'd like to ask one thing about the coordination of Planned Parenthood Clinics with expectant parents' class education. What involvement do you have in New York? Do you have a close communication? I've worked in two states with the Planned Parenthood Association, one in Michigan (Ann Arbor and Ypsilanti), and one in Omaha, Nebraska. In Ann Arbor we were stationary - our clinic was held in one place and people came to us; in Omaha, we were experimenting with a mobile unit - we drove a bus into the more or less ghetto areas. I wondered what experience you have had with people coming to each kind of unit?

MRS. HUTCHINSON:

You mean such as mobile units and what not?

MRS. KRAPOHL:

Yes.

MRS. HUTCHINSON:

Many Planned Parenthoods do use the mobile unit. In Hawaii they use an airplane. I think they have good success with them. One problem with them at this point is that sometimes women prefer to come to an anonymous building where when they walk in nobody knows whether they are going in to have their hair done or to get their contraceptive. Mobile units have a way of saying "Birth Control Clinic" and everybody's neighbor knows where you are going. Some people don't mind, so there are goods and bads about them, I am sure.

Back to your expectant mother education classes, I think most family planning agencies are working very hard to introduce contraceptive information and care within the context of comprehensive health care. In many of the maternal and infant care programs popping up, family planning is offered as a part of this service. This means you get your prenatal, postnatal and contraceptive care all in one place which, afterall, only makes good sense.

MRS. PILPEL:

I think it's hard to imagine in an area where you don't have government services what a difference it makes in an area where you do. I mean the City of New York has a major family planning program. Much of it is tied to the maternal and infant care divisions which are in the hospitals and in the city health stations. I know that Dr. Edwin Daley, who is one of those in charge of that, thinks he has the largest family planning service in the world and indeed he may. And they have certainly worked with expectant parents because that's the way many of them come in. They have also found that the most effective workers, in line of what this gentleman here said, Mr. Fontera, are members of the same community. And he has a number of very brief courses for community people who then go out and approach other people in the community and they have found that these women were by and large in many of these areas not even educated except in this specific area do much better than the highly educated social workers, nurses or doctors.

DR. ROGERS:

I would like to add one thing to what you said, Harriet, and that is that these people whom Dr. Daley has trained not only go out into the community, but groups of them are assigned to each of the New York hospitals and they contact every female patient in those hospitals, not just the ones on the maternity wards, but the ones who are there for surgery, medicine and everything else. They cover the entire female hospital waterfront.

MRS. KRAPOHL:

I would like to know then the reception of these people by the hospital staff and administration when they come in.

DR. ROGERS:

Well, I can't answer that entirely except to say that I think that now they are quite well accepted. I'm sure that it wasn't all a bed of roses to begin with. But I think that I'm correct in saying that most everybody connected with not only the maternal and child health program, but with the hospital, is very enthusiastic about this.

MRS. PILPEL:

There is such an extreme shortage of nursing care and of other professional help in the hospitals that whatever may be of the antagonisms at the beginning my impression is the same as Dr. Rogers, namely, that anybody who can help to meet an almost insoluble problem in terms of care and contact is welcome now.

DR. FONTERA:

I think it's larely likely to continue to be a question of priorities. I know the shock with which it was uncovered that bribery is a great motive for male sterilization. And the sort of moral fright with which that was first reacted to and now we're at the stage where there are learned economic and social discussions about transistor radios versus straight cash. And the difference is because the problem is perceived more widely and more directly in a given area. But I think one of the real gaps in what we're doing nowis lack of the transfer of learning. The difficulty we've had for many years in many areas with reinventing the wheel and not being able to move from a successful program in Taiwan and say that even though those people are Chinese and even though for several hundred years in this country the Chinese have been regarded as somewhat lesser beings at times, it is possible that we, even we, sophisticated East Coast American, Middlewest American section might learn something from the Chinese and from the Africans and from the Indians, etc. And one of the examples I would give for a kind of feeling that I have that programs have to be heterogeneous enough to adapt to different kinds of social structures is that in South India a good explanation for part of the success of a male sterilization program in Madras and Tamalmad State was that the program was a very heavy bribery program filtered down through an established social structure so that it became an economically beneficial activity, a bounty activity for village elders to engage in. And they utilized their social standing and the informal pressures they could place within the rural communities to bring men in for these very simple operations and procedures. And I think really that sometimes if we ask a bad question like, what ought the family planning program be in North America, we ought to ask ourselves whether the unit we're talking about isn't too large and whether we shouldn't be retentive enough of information in exchange to recognize that a program that works beautifully in Ann Arbor won't work at all in Peshtigo. And that without saying that Ann Arbor is a better or worse place than Peshtigo as a result. For instance there's unlikely, I think it's a safe prediction, to be any cry in Brown County against the family planning program on grounds of Black genocide. There's a good reason for that; there are no significant numbers of black people in Brown County. But yet the cry of black genocide is something that New York and Washington have had to face.

DR. SANDMIRE:

What I have to say is less a question than a correction or an addition to something that Dr. Fontera said because I think it's real important and it relates to the cost of a vasectomy - it's $90. Total cost in a clinic in Green Bay. I repeat - $90 not $350. Now, the total cost of a hospital vasectomy, that is, one performed in a hospital, I'm sure your figure is correct, but I think it's important for people to know that this can be done as a clinic procedure.

DR. FONTERA:

How many physicians are now doing this in clinics in Brown County?

DR. SANDMIRE:

At least one, and I cannot respond beyond that. There may be more, but this one who is, is not saturated.

Then, Mrs. Pilpel mentioned that sterilization was never a legal problem and it wasn't. Yet, certain hospital regulations have sought to prohibit voluntary sterilization. I think a milestone in this was the recent change in the policies of the American College of Obstetricians and Gynecologists which states that there is no consultation required, there is no number of children required, there is no age requirement to voluntary sterilization. Now again, to get back to the local situation, because people in this area desire this information, the hospital in this area allowing voluntary sterilization has no consultation requirement, no regulations prohibiting sterilization. Voluntary sterilization is available in Bellin Hospital entirely free of any barrier as far as hospital rules, consultation, or what have you.

DR. FONTERA:

Well, there are some sort of social action interconnections and one of them, of course, is the fact that if the water isn't too chilly for one or more physicians, a few physicians, perhaps others take courage from that. And I think that's an important matter. It occurred to me that this is also linked to the insurance question and I was talking about this during lunch with one of the people at the conference, and it occurred to me - and I don't know whether this is realistic or not - but, for example, the University of Wisconsin-Green Bay is a major contractor for the Blue-Cross-Blue Shield contract which covers employees. And I wonder what would happen if a major contractor - in fact it's a contract of the University of Wisconsin as a whole - were to demand that this coverage for what is now not covered, as I understand it, because a male sterilization is considered a plastic procedure like redoing your nose, and not a disease or medical procedure of that sort, that if a large contractor demanded that in their contract, what would happen? We're talking now about one of the largest contractors for Blue-Cross - Blue Shield in this state.

DR. BAKER (UWGB):

I just wanted to make the comment to Dr. Fontera that at the present my understanding is that Blue Cross - Blue Shield does in fact cover vasectomy.

DR. FONTERA:

That's not my understanding.

DR. BAKER:

Well, I'll assert it that they covered it in at least one case.

DR. SANDMIRE:

Well, insurance companies issue coverage and they base the premium on the predicted cost of the program. Anything is possible. But whether the procedure is performed in the hospital or office clinic does not determine whether Blue Shield would pay the physician's fee. Obviously, Blue Cross would not be involved in a clinic procedure because there is no hospital bill. Insurance companies like Blue Shield and private companies vary. Any contractor certainly can influence insurance companies to revise their policies. All they need to do is to make some prediction on what cost will ensue as a result of extended coverage. And I think that this should be covered by any insurance company presently not covering the procedure. On the other hand, I think there shouldn't be too many who would forego a vasectomy which is a $90 procedure, if they're really interested in obtaining the procedure. I probably shouldn't suggest this publicly, but some people don't pay their doctor bill. And about ten percent of them don't. And if the person was really short of the $90, he could probably get it and be one of those who do not pay the bill.

BEA KABLER:

We were somewhat put down in ascribing opposition to legislative change as coming mainly from certain groups. Perhaps, I should turn that around then and say that if that opposition is not as serious as some of you seem to believe, then the problem is that the people who support the change in the law are not vocal enough. Their legislators detect a certain fear and are themselves timid about taking action without having the support from the people in their constituency. So could I say to all of you here, please do find out how your legislator has voted on this issue in the past and thank him for his support and urge him to keep that position in the bills that will be coming. Senate Bill No. 2 will be one bill voted on this session, we hope. And if he has not supported the issue, please urge them to do so.

Now, an answer to what young people can do. A Portage County assemblyman, when I talked with him as a lobbyist at the Capitol, gave me absolutely no reason to hope that he was going to support family planning legislation. He was invited to a series of, I believe, three ZPG meetings on the college campus in his area. They sufficiently educated and converted that man's attitude that he did vote for family planning legislation. A rural, German-Catholic farmer, who said "I see my friends with land in the soil bank, so who says there's too many people and we can't feed them?" He had all the kinds of objections, yet they were able to educate this man to the point that he did vote for the bill and he said not long ago, "When I was born in a big family, we didn't understand about this population problem", and then went on to make some more comments. Such approaches can be effectively done in a persuasive, kind of easy sell way without trying to intimidate or threaten. Please help us.

MRS. KRAPOHL:

I don't know how important this is, but I've done some reading that tubal ligations are being done as out-patient procedures in larger institutions. Would a tubal ligation be done as an out-patient procedure. How many tubal ligations are being done in out-patient departments? It seems much more troublesome to have a woman with children at home go into a hospital for a tubal ligation when it could be done as an outpatient procedure. I'd like advice from the physician on the panel.

DR. SHUBECK:

I'm not aware of anybody who is doing tubal ligations as an out-patient procedure in this country. I know they are doing some in Mexico City through the culdoscope, but most of the patients who have laparoscopy tubal sterilizations are kept overnight, since they get general anesthesia.

DR. DAVIS:

I'd like to extend to Dr. Shubeck an invitation to Baltimore to see what is going on in this country.

DR. SHUBECK:

Invitation accepted.

DR. DAVIS:

For some time now, Dr. Clifford Whelis has mastered the technique of laparoscopy and has proceeded to pass this skill on and we now have probably one of the most active groups in this field. It's reached the point where it's practically crowding out the rest of the operating schedule. Arrangements have been made whereby the women come in fasting and they get a light 20-minute anesthesia. The procedure of laparoscopy, for those of you who are not familiar with it, is a matter of inserting an instrument about the diameter of a fountain pen (a little larger than a ballpoint for those of you not familiar with antediluvian instruments) through a little puncture incision just below the belly button. This allows one to peep, as it were, through a little telescopic arrangement and see the tubes which are then treated with an electric current. The whole procedure takes about 20 minutes. A bandaid is put on this little tiny slit and the husband collects the woman within a matter of three hours and takes her home - whenever he finishes his work. Some of the women have gone back to work the very same night; we usually advise them not to go back to work until the next day. But they do not stay in the hospital. The total package, including the anesthetic and the technical procedure, has been arranged by our administrator for a cost of $125. I'm happy to say that we have a very enlightened State Health Department which will pay for indigents and I'm unhappy to say that administrators of some of the insurance companies (although Blue Cross-Blue Shield will pay in our State) seem to think that babies are cheaper than sterilizations. Perhaps they're John Birchers - I don't know what their problem is, but I suspect that they will change.

To make a long story short, this has become so popular that we are now booked up two or three mornings a week in one of the operating rooms set aside for this purpose, and we've done about 700 of these procedures since July 1 - in just a six month period - we just looked at the data. We have women now going on pills and having IUD's put in them while they're waiting for it because we can't get them in fast enough. It's a real step forward.

DR. TAYLOR:

I would like to exercise the perogative of the chairman just once and ask Dr. Davis if it's done under local or general anesthetic?

DR. DAVIS:

We have done some under local, but by and large it's done under a fifty-minute general anesthetic. We are not doing them as they are in Mexico City under a local. It's a bit painful to put an electric current, to buzz the fallopian tubes with an electric current, without being asleep.

DR. SHUBECK:

Let me say this - in Mexico they don't use the current down there. They tie the tubes - they tie them and cut them.

JOHN VAN MILLER:

Can I ask Dr. Davis a question? It seems that at least from what I gather that you are using this procedure more often than vasectomies. Is this correct and if so, why does this seem to be preferable?

DR. DAVIS:

Well, I don't know that it is preferable. Fourty-four percent of the patients who deliver at our hospital are not married. And a good third of the women delivering at our hospital are under the age of twenty. I think vasectomy is starting to become popular in the middle class population that's settled and perhaps thirtyish or fortyish. So when we're talking about vasectomy, we're talking about probably a different group. But I think it will be quite some time before it filters down to the population I'm talking about.

MRS. KRAPOHL:

Well, just for my own alma mater and Dr. Shubeck's, I was at a workshop last April and Dr. Schneider who was very active there mentioned that in their out-patient department they are doing tubal ligations. How they're doing it, whether they're doing it with sutures, or whether they are doing it with electric current, I'm not sure. But they are starting to do it. Whether they're as active as Dr. Davis, I'm not sure.

MRS. LEPIANKA:

A lot has been said about voluntary sterilization. Although when you bring it down to an individual case of a person walking into an office, they usually have a lot of static about questions - are you really sure; come back and see me again after you have thought about it. If a person in their own moral mind feels that this is what they want, why is there so much static for both female and male sterilization? Is it necessary for the State, I mean is there some law that states something to do with this, or can a person just now go in and somewhere else like a private clinic? Is it necessary that all the questions be asked? I think this scares away a lot of people.

DR. SHUBECK:

Well, people have been known to change their minds and if you have given them an opportunity to do so, then the next time they come around you feel as though they really had the opportunity to think about it and to go ahead and do it. But there's no objection to somebody walking into the office and if the doctor wants to do it - sure, then go ahead and do it. But a lot of physicians are conservative, much as they are conservative in treating teenagers for example. You know, you run the risks of a possible suit at any time. And if you've given a patient an opportunity to really think about a certain operation that has to be performed or that they want to have performed, and they go ahead and do it without running any risk of it. It's a legal risk and also a moral obligation a physician has to a patient to give him the opportunity to be sure that that's what they want to do because sterilization is considered to be permanent.

DR. TAYLOR:

The hour is getting late. We've had a lot of discussion and I think if there is a member of the audience who has a burning question - well, that's not right, that's unfair - a member of the audience who would like an opportunity to ask a question who has not yet done so, I would throw the floor open to him or her, and, if not, then I think I wish to thank the panel members for their - Dr. Shubeck has not been satisfactorily thanked for his talk in the first part of the afternoon - and the other panel members for their contributions - all of you. And I also wish to thank the audience for the very thoughtful questions which they put forward and also for the many worthwhile - I don't want to sound patronizing and I have no intention of sounding that - for the many very good comments which they have made.

Ladies and gentlemen, the session is closed. Thank you.

SESSION THREE

Friday, 8 January, Evening
Beaumont Motor Inn

Session Chairman:

Dr. Richard M. Fontera
Special Assistant to the Vice Chancellor
The University of Wisconsin-Green Bay

Speaker:

Dr. James F. Crow

Consequences of Family Planning For Man's Genetic Future

James F. Crow, M.D.

Chairman
Departments of Medical Genetics and Genetics
The University of Wisconsin
Madison, Wisconsin

My title has to do with population quality, and in particular genetic quality, but I'd like to say at the outset that to me the major problem in the human population is quantitative and not qualitative. Unless there's a world-wide catastrophe, such as nuclear or chemical war, we're facing a world with too many people. There is room for considerable debate as to how many people a technologically sophisticated society can feed, but I am interested in the quality of life; some wilderness, some privacy, wildlife - the finer things of life, and for these in my view we already have far too many people. I'm reminded of what Bertrand Russell said on this point. He was talking about the arts, about philosophy, and about music, and he said these are called the finer things of life only by people who have never been hungry. I want to emphasize that we have both the problem of maintaining sufficient food for the world and, in addition, the problem of providing what we all hope can be a much more enriching life.

I appear here slightly apologetic and somewhat shaken by having attended about a month ago a conference on the role of human genetics in the welfare of the country. A good representation of human geneticists attended this conference and were vigorously asserting that it is in the national interest to support research in human genetics when one of our members got up and said that we geneticists don't really have a very important role; that it's much more important to control the total number of people in the world, and that population geneticists and molecular geneticists had better stop worrying about the quality of the population

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and start worrying about something more important. He had quite concrete suggestions as to how geneticists could retool themselves to do something more useful. In particular he pointed out that molecular geneticists and those who were concerned with the relationship between enzymes and genes might very well stop this fascinating work, start working on reproductive physiology, and try to invent a better contraceptive. He said those that are interested in population genetics are pretty well prepared to take up a subject like demography, and he suggested that we immediately do so. He said those that have any kind of medical proclivities can get into clinical services; there are all sorts of birth control clinics that are badly in need of staffing - much less in need of talking, far more in need of working. There are administrative problems that would tax the sincerity and the capacity of the president of any great university, and he said if you don't have any of these special skills you can always run for public office.

I agree that we need better methods of birth control - cheaper, more effective, more available, more widely accepted. We need abortion readily available, prompt, and cheap, if not free. We need a society in which people with more than two or three children are regarded as socially irresponsible and morally reprehensible. The last time I made this statement it turned out that the man who had introduced me had six or seven children.

My topic, however, is the problem of genetic quality and I want to discuss what's likely to happen genetically to a population which has stabilized. The reason it's worth talking about is not that I think this is the most pressing problem of human society, but for the reason that the more successful you people are, the more important the problem I am raising becomes. The nearer we come to a population in which each pair of parents has exactly the same number of children, the more important will become the genetic consequences of such a situation and I for one want to start talking about it now. As infectious disease disappears, as is happening in our society, genetic diseases cause a larger fraction of the total morbidity and mortality, and we are, therefore, going to have to pay a larger relative amount of attention to them. Whether the absolute increase is any greater depends on how one chooses to measure the cost. There's an elementary fact of life, which is that each person is born once and dies once. If he dies of an infectious disease, he usually dies of a disease that is cheaper to take care of and costs society less in terms of doctor and hospital bills than if he lives considerably longer and dies of a disease that is genetic in origin and which often costs a great deal in terms of medical and other kinds of expenses. I think it's almost inevitable that whatever we do in our society that prolongs life is going to prolong the length of time it takes to die and, therefore, the cost of living and dying.

Another aspect that deserves emphasis is that one of the almost certain consequences of our highly industrialized and chemically sophisticated society is that among the plethora of chemicals that we're putting into our atmosphere, water, and food almost certainly some of these are having a genetic influence by producing increased mutation rates. We don't know this, but the likelihood that some of them are having such effects seems to be very nearly certain, and I want later on to say a bit about this.

The subject of genetics started in the year 1900 and has now had seventy years of existence. I'll remind you that seventy years is approximately the time that's required to double the size of a population that is increasing at the rate of one percent per year (just to show you that I'm still staying reasonably close to the general theme of this conference). During these seventy years, the chief beneficiary of increased knowledge of genetics has been agriculture. We're well aware of the fact that agriculture has profited greatly by the detailed knowledge of genetic processes. Actually, animal and plant breeding uses many ideas that were well understood before Mendel existed. The rule that like begets like is still the basic breeding guide. The principle that if you select the best parent you'll probably get the best offspring didn't have to wait for the scientific sophistication of the twentieth century. Actually, of course, we can do better than this by using Mendelian principles and sometimes by circumventing them. If I haven't made myself clear, let me say a bit more. The major feature of Mendelism is sometimes the major difficulty, for Mendelism is essentially a coin-tossing process. And although this makes the subject of genetics interesting, it also makes it less predictable. Every instance of reproduction involves with respect to every gene a sampling process. Much of the success of plant breeders has been due to the fact that plants are less restrictive about how they reproduce than animals are and it's often possible to bypass the sexual process of reproduction and replace it with something that's less random. The hopes for doing this in animals are partially realized and the possibility for this in the human population is around the corner, perhaps not too far.

The development of hybrid corn has changed agriculture enormously in this country and in more recent years the developing of high yielding strains of rice has changed Japan from a country that used to have not enough rice to feed its own people to a country that doesn't know what to do with all the surplus that it now is producing. In the United States one of my colleagues had developed a strán of corn which is good in the one respect in which corn is notoriously bad. As you are probably aware, the great defect of corn as a nutritional agent is that it doesn't have enough of certain amino acids. He has developed a strain of corn that's high in the proportion of lysine, thus repairing the defect. This can make an enormous difference in the food supply of these parts of the world which depend almost entirely on corn as a source of calories. Such enormous agricultural applications will undoubtedly continue, but the impact of genetics in the next third of the twentieth century is almost certainly going to be directly on human society and that's what I particularly want to talk about.

Every school boy, though hardly ever his parents, is already familiar with DNA. Whenever I speak to a group of people about the beauties of the DNA double helix I find that the high school students in the audience have already heard it while the adults think it is something rather mysterious. I don't intend to draw Watson-Crick helices on an imaginary blackboard to my back. I'm a schoolteacher by profession; I'm slightly uncomfortable in a position like this without a piece of chalk, which is a comfort symbol - it doesn't really require a blackboard, simply holding the chalk makes one feel more at ease. When I was a graduate student, we used to spend quite a bit of time at the local tavern and some of this time I won't tell you what fraction, was devoted to speculation about the nature of the gene. At that time we thought that not in our lifetime would it ever be possible to understand what the gene is. And the reason we thought so was that the prevailing view at the time was that if we were ever going to understand the nature of the gene we would have to understand the nature of the effect produced by the gene. If one were going to understand the nature of the gene that causes muscular dystrophy, for example, he would have to understand the nature of muscular contraction. To take another example, if one were to understand the genes for the human eye pigment he would begin by first understanding what the eye pigment is. And then after you know this chemistry, you might try to understand the chemistry of the process that produces the pigment, and then you might understand the chemistry back of that chemistry, and then after X number of steps going backward in chemical simplicity and backward in time in the developing embryo, you would eventually get back to the gene. Finally, five hundred years from now one would understand the nature of the gene itself.

There was a generally prevailing view that you can't understand how something can be messaged and encoded and translated unless you understand the process itself. I don't have to tell you that the whole history of biology in the intervening twenty years has been totally different from this. We do understand the nature of the genetic message despite the fact that we often don't understand what the message is all about, just as we understand the English alphabet and the system of spelling and punctuation, even though there are passages in Hamlet which defy complete understanding. What I am really saying is that what we've succeeded in understanding is the nature of the transmission and translation mechanism more than the deeper implication of the message itself. Nonetheless, I'm still amazed by this and I think if we had a man from Mars here tonight if I told him that we understand how it's possible to inherit the ability for a muscle to contract without having anything like such a deep knowledge of muscle contraction itself, he would think this foolish. And an even better example is the fact that we understand how such a thing as the ability to think can be inherited when we haven't the foggiest idea of what the ability to think is. To reminisce just a bit longer - I'm avoiding at all costs getting down to the subject - I used to give talks to laymen and I would say that heredity isn't hard to understand. You ask yourself about memory, you understand memory, and heredity is something like memory and that's all you have to say to understand it. Nowadays one turns the story around completely; much of the speculation about the nature of the mind is based on DNA, RNA and protein models.

With the kind of detailed depth of understanding that we have of the gene, there are bound eventually to be practical consequences.

As we look into the demographic changes that are happening in the human population, the most striking thing from the standpoint of our genetic constitution in future generations is that the law of natural selection has to a large extent been repealed and when it hasn't been repealed, it's often been changed. In the past a newborn individual had a small chance of surviving to maturity; part of the causes of his survival or non-survival were his own genetic constitution and, therefore, natural selection could operate through differential mortality. Nowadays the infant has a very good chance of surviving and reproducing, and only a very small fraction of them die. The possible role of natural selection by postnatal death is thereby reduced. On the other hand, one aspect has changed very little, and that's prenatal mortality. There hasn't been any significant change in the fraction of stillbirths and abortions in the recent years - nothing like what's happened with postnatal mortality.

Now if we ask ourselves also what has happened with respect to differential birth rates, this story isn't so obvious and it's rather interesting what some of the effects are. In the first place, we have to know how to ask the question. It doesn't do much good to say that the average number of children per parent has dropped from half a dozen down to two or three as it has in the United States. What we have to know in order to make any kind of decent assessment as to what's happening to the future genetic composition of this population is whether the two or three that represent the average number of children per parent is a uniform number or whether it is a highly variable number. Any opportunity for natural selection to operate depends on how much variability there is in the population, not on the absolute rate of reproduction. So one has to ask what's happening to the variability in the number of children produced per parent.

It turns out, and I won't try to explain why, that the best measure for this is the variance (that is the average squared deviation from the mean) divided by the square of the average number. If you compute this quantity for human fertility and see what's happened to that during the last forty or fifty years, you'll see that it has done a very interesting thing. In the late 1800's the average family had a very large number of children, but there was a uniformly large number of children and not much difference from family to family. Then we went through a period in the

1920's and 1930's in which the average number of children dropped quite precipitously, but in which the variability from family to family rose considerably so that actually there was a much greater differential contribution to future generations in the early 1930's than there was in the late 1800's, despite the great reduction in the birth rate.

I don't want to assert - in fact it would be highly naive to say so - that the factors governing human fertility and reproductivity were strongly related to genetic properties. They probably had much more to do with access to birth control information, economic status, and other things that are largely unrelated to biological fertility. But at least the opportunity for natural selection actually increased despite a rather striking drop in the birth rate. Recently, though, this has reversed. The birth rate has gone up a bit, then back down again, but with the current dropping down again there's much more uniformity than previously. The variance is far less than it was in the early 1930's. Whatever the causal factors are, they're far more uniformly applied to the population now than in the past. To give one simple quantitative measure to all this at once: if the causes of death and differential fertility in the human population were natural selection we would be evolving just about half as fast as we were at the latter part of the nineteenth century. I don't think this is a realistic thing to say because I don't think the factors determining these demographic changes are those influencing genetic characters, but in any case opportunity for selection to take place has dropped by some fifty percent.

One question we can ask is this: if we are successful in our efforts to persuade the population to attain a stable size and if this takes the form of essentially a constant number of offspring per parent, what does that mean for the future genetic makeup of the population? One can only answer this question quantitatively if one has an exact picture of what's likely to happen, but I think we can get a good qualitative idea from very elementary consideration. Let's imagine as an extreme that we have a population in which there is no differential mortality or fertility; that is to say, population control has been totally successful in the most extreme of its aims and we've assured that every pair of parents has two and only two children. Also, let's assume that there are no pre-adult deaths. What's the consequence of such a situation? Well, an immediate answer to this is that there is no consequence as far as gene frequency changes are concerned because if there is no differential reproduction, there's no basis for selection to increase or decrease the frequency of any genes in the population. Any changes would be caused by random fluctuations. This would mean that the incidence of diabetes or any other disease that has some genetic component simply wouldn't change as far as the effects of selection are concerned. But there's one factor that I have left out of this picture and that is the effect of mutation. Because gene mutation is going on all the time, I think the major consequence of success in achieving a stable population and a uniform reproductive rate within the population is that mutation becomes a larger factor for human welfare than it has been in the past, and, therfore, is worthy of increasing attention as a social concern. Of course, no such extreme situation exists, but by examining the extreme we can understand the consequences of a lesser change in the same direction.

There are some other trends in our society that I also want to say a little about. One thing that has so obviously been happening that it's pointed out every time one discusses this kind of a question is a much greater mobility of the population. We're much more likely to be born in one part of the country and reproduce in another part than was true one or two generations ago. This has two interesting and quite important genetic consequences. One of these is that there is less inbreeding in the population than there has been in the past, and this means less of whatever diseases are increased by inbreeding. One could probably demonstrate this demographically, but as far as I'm aware it hasn't been done. I have more faith in our ability to calculate this than I have in our ability to show it from any real data. We are slightly more healthy insofar as this is genetic because of population mobility.

Another effect of increasing transportation and mobility in the population is a greater stratification, at least for some traits. I am impressed by the strikingly high correlation between husband and wife for all sorts of traits. There is a strong correlation between husband and wife with respect to height, about twenty-five percent. But the one that is really striking is the IQ. Whatever IQ scores measure and whatever it is that husbands and wives see in each other, they are the same thing, or at least they're strongly correlated. I suppose there are some common variables such as the number of years and place of education that lie back of this, but one study after another shows that husbands and wives are correlated to an extent of fifty percent, sometimes sixty percent, which is higher than the expected correlation between parent and child.

What consequences does this have? It can have, I think, quite a consequence by increasing the variability of the population. This means that we have more geniuses and more mentally retarded than we would have without assortative marriage. Now, do you think this is good or bad? I would like to assert that I think it's good. I think our society owes so much to Mill, to Einstein, to Mozart and their like, that this is a salutary influence.

To carry this Pollyanna trend just a bit further, I suspect that the population to some extent is having its cake and eating it because assortative mating is much more striking at the high end of the IQ scale than it is at the low end. So it may be that we are shifting the shape of this distribution, skewing it toward the high IQ score without a corresponding spread at the low end of the scale; we may be actually living in this best of all possible worlds of having an increase of high intelligence scores without a correspondingly enhanced frequency of low scores. I guess

I should have said at the beginning, I'm quite willing to assume that high intelligence is better than low intelligence. I realize, of course, that not all would agree.

Two other things that are happening as a consequence of reduction in natural selection and the improved environment that's the cause of it all: one of these is that diseases that used to be fatal or used to interfere with reproduction are now being cured or patched up in such a way that the person has normal reproductive capacity. And, therefore, these genes are passed on to the next generation in a way that wasn't true in the past. That this is correct I think there can be no serious doubt. But it's not a very useful thing to say that we are passing on more harmful genes to the future generation than our predecessors did, unless we can be quantitative. This is important if the effect is large, it's unimportant if it's small, so I want to be somewhat quantitative about it. Now, one can answer these questions with precision only for simple cases, and I'm not sure but what we mislead ourselves if we discuss only simply inherited traits and brush under the rug complexly inherited traits. But I'll follow this standard academic custom of talking about the things we know about and ignoring the rest.

I will talk about two examples. A very convenient disease for the purpose of this discussion is phenylketonuria (PKU). This is the recessive condition in which the person is unable to metabolize one of the amino acids and as a consequence of this can't think, and as a consequence of not being able to think, usually ends up being institutionalized. Now, that it's understood that what's wrong with these children is there inability to convert phenylalanine into tyrosine, it has been shown that by feeding them a diet which is very low in the amino acid phenylalanine this deficiency can be repaired. Whether it's a complete repair or whether it's only partial is going to depend upon a lot of careful testing that still isn't complete. The problem is that if you raise a child that's hopelessly retarded and he has an IQ of 95 after you get through, does this mean that this is what he would have had without the defective genes or might it not have been 105? But in any case, the child is brought up into the level of intelligence that assures normal reproduction. So this particular disease is now going to be transmitted to the next generation, rather than held in check by the failure to reproduce each generation.

Stated in these terms it sounds pretty alarming. Actually, one can calculate what the increase next generation will be and it's about two percent. The increased incidence is twice the frequency of the gene multiplied by whatever increase you make in the reproductive performance. In this instance, it's easy to calculate because we know the frequency of the gene is very close to one percent. We know the improvement which is from practically 0 to practically one, that is from 0 to one hundred percent. So multiplying these quantities together I get two percent.

So we can predict that the incidence of phenylketonuria next generation as a consequence of repair of all cases this generation instead of being 1 in 10,000 is 1.02 in 10,000. I don't see anybody being alarmed about raising the incidence of a disease by two percent when it's that rare to begin with. The immediate benefit far outweighs the harm in the near future. But I do have to say that this is an exponential, compound interest increase. It would take about thirty-five generations to double the incidence of disease. This is about a thousand years. If we survive other problems for that long a time, we're going to have twice as much phenylketornuria as we have now.

So far as rare recessive traits are concerned, we can repair or cure them and the consequences are so small and so far in the future that I think we can safely afford not to think too much about it now. I'm acting on the assumption that if we have descendants at all a thousand years in the future, they're going to know more than we do and they'll be able to deal better with this kind of a problem than we can. On the other hand, if I ask about a disease that is caused by a dominant gene, the story is really quite different. I have an example for this, a rather nice one to talk about.

There's a condition called pyloric stenosis; it's simply the failure of the connection between the stomach and the intestine to open properly. The sphincter muscle contracts when it shouldn't. Up until the early 1910's to 1920's this was fatal to infants because it wasn't understood. Then a British surgeon invented an operation to repair the defect. The children recovered completely and had a perfectly normal life. And it's not, I'm told, an especially difficult or dangerous surgical procedure. It didn't get used widely because of World War I and so the widespread application of this, especially in the United States, didn't begin until the early 1920's. Children born in the early 1920's are now grown up and have children of their own so there's a chance to ask a question that couldn't have been asked earlier; is this a heredity condition or not? If everybody dies it's a frustrating situation to a geneticist, he can't tell much about the inheritance under these circumstances. But now that the children survive this operation and produce children of their own, one can ask whether this trait is transmitted in a high frequency; and the answer is yes. It's not a simple Mendelian example; but among the persons who have been repaired for this particular defect, their children show twenty-five, thirty-five, forty percent frequency of the trait. Now, again whether you think this is an alarming thing or whether you think it's something that our society can take in stride depends partly on your economic optimism. One way of looking at the situation is that as far at this particular trait is concerned, we're going to have to have more surgeons than we had a generation ago to take care of the predicted increase. I think perhaps that's the closest kind of an assessment that a geneticist can make of this situation. Our population is not likely to embark on any wholesale eugenics programs, so I think what we have to do is plan for the proper kinds of environment to take care of the genetic failures of this generation. I don't want to call them general failures; they're social successes but they produce genetic problems for the next generation and we should plan for the predictable increase of the need for various social services and especially medical care.

One other thing: it's already possible and it's going to be increasingly feasible to detect more and more diseases while the child is still an embryo. And then by an elective abortion, one can simply eliminate those particular children that are destined to have highly deleterious diseases. At the moment, this is most satisfactorily practiced for diseases that are chromosomal in origin. You can recover a few cells from the amnionic fluid, look and see if these cells are chromosomally normal, and determine whether this child is going to develop into a normal child or not.

Within the past year, there are half a dozen or so non-chromosomal diseases, that is genic diseases, which have a detectable cellular basis; and if the disease has some effect that can be detected on the individual embryonic cell level, it can be detected by this method. So increasingly in the future, it will be possible to diagnose more and more diseases in early fetal stages, stages that are early enough that an abortion can be performed. One can ask what the genetic consequences of this are. This depends in a curious and interesting way on what the birth control practice of the population is. If we attain something like zero population growth, is this going to mean that a family which is producing one-fourth abnormal children instead of having two children will have only one and one-half because of the one-fourth that are abnormal, or does it mean that they will simply compensate by having two normal children? If they follow the latter practice the gene will tend to stay in the population. Now again the differences are so small that this is more an interesting intellectual exercise than it is a practical question; but if we look for the long term future maybe we should start thinking of a policy which says that when a family has a child aborted for carrying a highly deleterious stage, instead of having the average number of children in the population, it have slightly less than the average number. I'm not ready at all to advocate any such immediate policy, certainly not any compulsory procedures of this kind; what I am seriously advocating is that we start talking about it, start thinking about it, and thinking of it as one consequence of what I hope is the ultimate success of the population stabilizing movement.

Now, I want to say a bit about mutation; I alluded a while ago to the argument that we're reducing natural selection. A major role of natural selection is in the elimination of harmful mutations as they occur. Our whole past history, our whole present success is ultimately a result of mutations. Of these mutations which occur, mostly harmful, the small fraction that are beneficial are retained by the sifting and winnowing process of natural selection. If this process is less effective (we, of course, haven't abolished it entirely). the accumulation of mutations is going to go on faster than their elimination. We're probably having right now a slowly increasing frequency of mutations in the population. Whether this will be felt or noticed as an increased death rate or as a decrease in something that we regard as good depends mainly on our ability to compensate for this by steadily improving the environment. If we get into such a state that the environment gets worse, then we are in trouble because we have not only the current mutations, but also the accumulation of those that have occurred in the past and have been sheltered by a favorable environment. I guess the take home lesson is that when we start environmental improvements we must keep them up from this time on. Almost any social innovation that has any kind of a genetic consequence is either going to have to be compensated for ultimately by some sort of eugenic program or we're going to have to keep that particular innovation from here on. If we cure a certain number of diseases this generation, we can expect to have to cure some of their children next generation plus the new mutations that have occurred in the meantime. Can we quantify this for complexly inherited traits? Not very well, unfortunately.

At least we would like to know something about the time scale. If you'll trust data from fruitflies, which is the only place I can answer this question at all, the time of attainment of a mutational equilibrium is roughly thirty or forty generations. So probably the effect of a total relaxation of a natural selection would mean that over the course of thirty or forty generations, we would attain about twice as much disability as we have now. Well, since thirty or forty generations is far longer into the future than we ordinarily plan, we're not dealing with something that's urgent. We're dealing with something that we should be thinking about, but we have the leisure to approach this problem intelligently, rather than having to start out with some kind of a crash program. But one thing we should do it seems to me, is to pay considerable attention to the possibility of mutation-enhancing influences in the environment.

As I think back over recent social and biological history, I am much impressed by the fact that the discovery that x-rays produce genetic damage was made in 1926 and the discovery of nuclear fission and fusion came later. I don't think there's any inherent reason why these two discoveries had to be made in that order. I think that it was a lucky accident of history that we knew that radiation was harmful before we discovered nuclear energy, otherwise we would probably be doing a great deal of unwitting harm to our descendants. I would be the last to assert that our present practices of radiation protection are perfect, but at least we're not totally ignorant of this subject and we have a widely accepted public policy of being very, very careful about radiation. It seems to me that the same question arises with respect to chemicals in the environment. In contrast to the radiation question, we've hardly even come to grips with the question of mutagenic chemicals in the environment. Not because people haven't tried, but because the problems are of much greater difficulty. I hope very much for more and more sophisticated and detailed (and unfortunately expensive) tests for mutation-producing properties of all the chemicals that are new in our environment. I have in mind food additives, pollutants, drugs, fertilizers, insecticides, contraceptives. As one of my colleagues said, "A contraceptive should either be non-mutagenic or effective", and hopefully both.

One generation of no selection is roughly equivalent to doubling the mutation rate. So in a sense we can trade off environmental improvements against an increasing mutation rate on this basis. It would be very nice if our technology could produce some way of reducing the spontaneous mutation rate so that every time we make an environmental improvement we could have compensatory reduction in the mutation rate that would leave the population no worse off. Unfortunately, I haven't the foggiest idea how to do this or whether it's even likely in the foreseeable future. I would like, however, to propose along with ZPG, zero population growth, ZMR, zero mutation rate, and assert that the ideal mutation rate for the human population rate is simply zero.

Somebody, if I don't forestall it, will immediately jump up and say "but if we had a zero mutation rate, we wouldn't have evolved, we would still be amoebas or viruses or apes, or whatever we were when mutation stopped." This is undoubtedly true, but I'm not especially concerned with the next 100,000 years of human history; I'm concerned with the next few dozen generations, or few dozen years even. On this point I'd rather like to quote J. B. S. Haldane. He pointed out, not quite in these words, that if you consider the enormous variability in the human population, if you compare the intellect of Newton with the village imbecile, or the musical ability of Beethoven with your tone deaf neighbor, or my athletic ability with that of the Green Bay Packers, or any other extremes that you can think of, and then if you consider the various permutations of these that you could put together, human variability is really enormous. And it's hard for me, and it was even hard for Haldane who had far more imagination, to think of anything he would like to do with the human population that couldn't be gotten by recombination of the genes that we now have. In other words, we don't really need mutations. He said that he could conceive of a situation in which this might be true; we might like to develop a race of angels instead of men and for this we would have to have new mutations because, as he put it, we don't have any human genes for wings, nor do we have genes for requisite moral character. I don't think we are going to run short of genetic variability for a very long time. If we ever need mutations we surely know how to get them.

I want to conclude from this that family planning is creating a problem for our genetic future and the more successful family planning is, unless it's accompanied by a planned pattern of reproduction to compensate for genetic differences, we're going to have increasing problems in the future; but quantitatively they are relatively small and are certainly not nearly large enough to be any kind of a deterrent to a family planning program. I think it's very important for geneticists to assert that, although we have concern with the genetic future, our real concern is to seeing some kind of a stable population first in order that we have a future worth worrying about.

Now, I have talked almost entirely about the possibility of a decline in the human population. I want at least to ask the question whether we're content simply not to get worse, or whether we have some more noble vision of humanity, which I do in my own mind. I am concerned with intelligence, with mental and physical health, with cooperativeness, and with similar behavioral qualities of our human population. However, as I said earlier, I don't see any tendency whatsoever for our society to take any of the kind of steps that would be required to make any concrete genetic changes in the future. I think that the reasons we ordinarily give for not being eugenists are probably not the real reasons. We say that eugenics is slow, or we say that the results are unpredictable. I think what we really mean is that we're not willing to accept the means. We're not willing to have any kind of persuasion, and, of course, not anything stronger than persuasion, that would govern the reproductive habits of this generation in order to insure a better supply of genes in the next generation. But I suspect that sooner or later society will have to ask itself about this question. How much are we deteriorating intellectually because of what I suspect are quite real birth differentials relative to educational or intellectual groups? Again, I suspect the effect isn't very great. I'm not an alarmist about this, primarily because I think these differentials were almost entirely the results of the stratification of birth control practices in the time when birth control was essentially a property of the educated. Again I'll quote from Haldane. He pointed out that in a capitalist society the unscrupulous get rich and the poor have more children and, therefore, you can predict some moral improvement. So far there's been no convincing demonstration of this having happened and I, therefore, offer his hypothesis hesitantly.

If we can't agree on positive aims of human society, and I don't think we can completely because some people will place emphasis on cooperative behavior, some on initiative, others on artistic abilities, still others on intellect. Probably we would agree, though, that variability is good; the last thing anybody wants in this society is a group of identical human beings. Fortunately, I don't have to advocate variability because Mendelian inheritance will take care of it. There is virtually no chance of selecting intensively enough to cause a reduction in variability from this cause.

There is surely substantial agreement on negative aims. Nobody in this room is going to maintain seriously that we should maintain muscular dystrophy, or severe mental retardation or Huntington's chorea in the population. Perhaps any serious discussion of eugenics can only deal with negative aspects of the subject. I'm aware of the possibilities for abuse of eugenics and of the setback that it had in Nazi Germany and elsewhere.

What can be done right now, and what is being done? I think genetic counselling can be of enormous social benefit. The numbers of individuals who are now being helped are an infinitestimal fraction of the total population. The statistical impact of all of genetic counselling is pretty small. But, if you count each prevention of a deformed or seriously diseased child as being important, as I do, then this becomes significant. I hope that the present trend toward increasing availability of genetic expertise for consultation purposes will continue. The ability to detect persons who carry hidden recessive genes by various kinds of tests on the persons themselves is a rapidly growing field. We know from various kinds of indirect calculations that on the average we carry some half a dozen genes in the hidden state that, if they were revealed, would cause a severe genetic impairment. As we learn more it will be increasingly possible for each person to say "I carry genes S, Y, Z and W and if you carry any of the same ones we either shouldn't marry, or we should be prepared to abort one-fourth of the conceptions". It's worth asking how much this will restrict the range of marriage partners. Calculations on this subject would suggest that if each of us had a complete inventory of the serious genes that we possess and we acted on the principle that we don't marry anyone who has any of the same genes, our range of choice would be restricted by two or three percent.

I want also to place great emphasis on embryonic detection. The technique is being tested on a large scale now to remove any doubts as to the safety of the operation itself; if this turns out to be reassuring, we're in a position within a few years to start this kind of a practice on a fairly large fraction of all children conceived. We can start with high risk cases and as the techniques become more and more acceptable, safe, and foolproof, this could be spread to a large population. Somebody told me, I can't vouch for the figures, that the economic cost of mongolism, just one particular condition caused by an extra chromosome, is more than a billion dollars per year. That could be removed at one fell swoop if it were possible to do the operation on every pregnancy. So there are possibilities for great reduction in particular kinds of diseases.

I can also see some difficulties that would arise from this. One of the consequences of perfect detection of the genetic content of every embryo is information about the sex of this child. So some people are going to be choosing elective abortion on the basis of the sex that they want in the child. This could possibly seriously distort the sex ratio. I prefer the biological method of determination right now, which assures an approximate 50-50 ratio, to human choices which may be quite capricious. If this were left as an issue to the voting public, there could be all sorts of results. I could see older people voting for a high male ratio and the young people opting for the opposite, because there are more males than females at age twenty and far too many females per male at age sixty. I don't think we should develop too many genetic engineering techniques without trying to foresee some of the consequences other than the most immediately obvious.

I would personally hope that artificial insemination instead of becoming a clandestine operation that's simply a private agreement between the obstetrician and the woman involved could at least be made public to the extent that the proper records are kept. If this becomes a widespread practice, there's going to be an appreciable risk that persons who are half-sibs and don't know it will marry one another with all the consequences of the inbreeding that this would entail. However, I don't think this is as serious now or is likely to be in the next few years as the same thing happening from more ordinary causes. I want to argue that the various legal restrictions on birth control, abortion and artificial insemination be removed.

I'm not going to talk at all about vegetative reproduction, clonal reproduction, egg transplant or genetic engineering, and I'll tell you why. These are all exciting prospects and intellectually challenging. But however exciting these are as intellectual challenges, they are not here now. I would rather talk about things like abortion and artificial insemination which we can do now and which do involve immediate social decisions.

SESSION FOUR

Saturday, 9 January, Morning
Environmental Sciences Building
Main Campus, The University of Wisconsin-Green Bay

Session Chairman:

Dr. Herbert Sandmire
  Obstetrics and Gynecology
  Beaumont Clinic
  Green Bay, Wisconsin

Speakers and Panel Members:

Dr. Edward W. Pohlman
Dr. Hugh Davis
Dr. James F. Crow
Dr. Dorothea Sager
Dr. Jeremy Green
Mrs. Evelyn Farrell

The Psychology
Of Family Size Desires

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Those concerned with population control and with family planning are naturally interested in understanding why some families have more births than others. That question can be divided into other questions, such as why people do or do not practice contraception effectively, have induced or spontaneous abortions, marry at young ages, and so on. All of these have their psychological aspects. One key question seems to be why people want fewer or more children.

If the use of effective contraception and abortion becomes even more common, the number of children people have will more closely mirror the number they want, and thus the topic of family-size desires will become proportionately more important. If parents want too many children to permit population stabilization, then population cannot be stabilized by voluntary contraception, sterilization and abortion alone, no matter how simple, effective, psychologically acceptable and commonly used these methods become.

My paper has four divisions. We shall first ask (1) what we already know with some confidence about family-size desires, then (2) how they may be expected to change "naturally" in coming decades, (3) what causes them, and (4) what might be done to change them artificially.

SOME THINGS KNOWN ABOUT FAMILY-SIZE DESIRES

What are some of the things we know about family-size desires?

Ambivalence

First, ambivalence is often and perhaps even typically felt by parents, The terms "unwanted child" and "wanted child" evoke the mythical stereotype of two completely separate baskets, one containing the lucky children who are one hundred percent wanted; the other, those unfortunate creatures whose parents (shame on the careless rascals) did not want them at all. As in most scientific matters, dichotomies need to be replaced with shades of grey in between. Most parents have somewhat mixed feelings as to whether they want another child. I have suggested a hypothetical scale to show the *degree* to which a conception is wanted or unwanted (Pohlman, 1970). Because of the special interest in the unwanted child, the scale is phrased in terms of that end of the continuum, and is called an Index of Rejection (I.R.E. or IRE) with zero representing a hypothetical extreme of complete acceptance and no feelings of rejection, and 100 IRE representing high rejection. This scale could represent an averaging of *two* parents' feelings, perhaps a weighted average if one parent is more present and important. Even this one scale is something of an oversimplification; how does one handle a hypothetical conception fairly wanted at a conscious level, but unconsciously fairly unwanted, or vice versa; or a child wanted for "sick" reasons; or a child wanted at one time but not later on, perhaps when a marriage splits up?

Because of changes over time, it would probably be best to identify an IRE score with the *time* to which it referred--before conception, during pregnancy, after birth, and the like.

Obstetrician-gynecologist Hans Lehfeldt (1959) coined the coloful term "Willful Exposure to Unwanted Pregnancy" to highlight ambivalence. He concluded that many of his patients *thought* they wanted to practice contraception successfully, but acted in ways that suggested that they really wanted another pregnancy. They persistently forgot to take their pills, use their diaphragms properly, and the like. This colorful idea needs to be checked with systematic research; we need careful psychological studies of personality characteristics and the hypothesized ambivalence of "pill-forgetters", for example. But we can say with some confidence that ambivalence is often a feature of family-size desires.

Rationalization/Dissonance Reduction

A second notable feature of family-size desires is that they often seem to involve a factor that may be described as rationalization or reduction of cognitive dissonance. There is some tendency to adjust family-size desires to reality. Grapes that you can't get are sour, and unwanted pregnancies that you can't get rid of are sweet. We may infer this from Table 1. This table is adapted from the Indianapolis study of *Social and Psychological Factors Affecting Fertility* (Clare and Kiser, 1951), and involves a random sample of certain Protestant couples. Men and women were asked to imagine that they could have exactly two children, and to indicate how many *boys* and how many *girls* they would like. Table 1 shows the replies of those fathers who happened to *have* exactly two children.

The table shows a strong tendency for fathers to say they want what they actually had. Two-fifths of the fathers with two boys said they would want two boys and virtually no other fathers wanted two boys. One fifth of fathers with two girls said they would want two girls; no other fathers wanted two girls. This fits with the hypothesis of rationalization or dissonance reduction: if you have two girls, but wish you had a boy and a girl, there is inconsistency or dissonance; to reduce this, you tend to shift your thinking and decide you want what you got.

But the table also clearly shows that there is a limit to this tendency; many fathers did not want what they got. The table also shows two definite preferences, (1) for one of each sex, and (2) for boy babies, but sex of child preferences are not our focus today. These tendencies, including the tendency to want what you got, were also found among mothers who had two children, and fathers and mothers with three children.

It is easier to study rationalization and cognitive dissonance in the case of sex-of-child preferences than in the case of family-size preferences. Hence we dipped into the sex-of-child data shown in Table 1 to find support for the contention that when people have an unwanted pregnancy, or more children than they originally wanted, they tend to change their preferences and say they want larger families.

Similarly, there are some data from a longitudinal study in Detroit suggesting that when couples have difficulty in conceiving additional children, they tend to scale down the family size they say they want. In a strictly scientific sense we do not have proof that rationalization or dissonance reduction or some such tendency operates concerning family size desires, but I would stake my professional reputation on it and feel we can list it as something known with a fair degree of certainty.

Changes in Preferences During Pregnancy

A third point is that family-size desires often increase during pregnancy. After an unwanted conception, many women change to decide that the pregnancy is wanted, and thus effectively add one child to their desired family size. Changes in this direction are many times more frequent than changes in the opposite direction (Pohlman, 1969, Chs. 12; and 1968). These changes are matters of fact based on research in this country; the explanations we use are more open to debate.

In other publications, I have reviewed the possible explanations for the widespread change from unwanted conceptions to wanted babies. The belief that pregnancy is an emotionally pleasant time is not supported by research (Tobin, 1957). If there are biological changes that make pregnancy more wanted, either they disappear after delivery, or the woman who already has three children should be taking them into consideration when she decides that a fourth is not wanted. I have concluded that the most probable explanation of changed preferences during pregnancy in most cases is rationalization of the inevitable fate. If so, then if induced abortion becomes increasingly available, I would predict that some women who would otherwise have resigned themselves to fate and decided they really wanted the hitherto rejected pregnancy, will terminate their pregnancies and thus be spared the pressure to reduce cognitive dissonance in this way.

Some have argued that women who do not want any children, or any additional children, should be encouraged to have them anyway, on the grounds that nature will take care of matters and they will learn to want and love them. This reasoning seems to be incorrect in terms of our evidence, and to have cruel results, both in terms of mental health of mothers and babies, and in terms of world population growth. The same villainous reasoning is sometimes used in denying a woman her request for an abortion, or in using supportive psychotherapy to nurse her through pregnancy so that she will not demand an abortion.

Too Many Apparently Wanted

A fourth point that emerges with some confidence is that if people in the developing countries continue to have as many children as they now say they want, population growth cannot be contained. This statement is based primarily on superficial surveys in many countries that ask people directly how many children they want, or think is ideal, and whether they want more children (Mauldin 1965). Asking a person point-blank one or two simple questions such as this hardly meets the requirements for sophisticated psychological testing. A conference in Berkeley next month will encourage the development of more sophisticated psychological testing procedures for family planning and population variables. For example, instead of putting most Americans in one of three categories because they want two, three or four children, it may be possible to develop a more graduated scale, fairly reliable and valid, based on probing limits of preferences in various ways.

While I welcome these trends and deplore the poor measurement procedures used to measure family-size desires so far, I suspect that even valid measures of family-size desires in most developing countries would show that people want too many children for population containment.

The same degree of reliability is not required if we are seeking only a group picture of family-size desires as would be needed if we wanted accurate measures on individuals. Asking people with a known number of children whether they want additional children seems to be giving them a question that is fairly clear-cut and unambiguous, and this question also suggests family-size desires too large for population containment. European birth rates seem to have dropped substantially in past centuries without fancy contraception, largely through the use of coitus interruptus; if people in developing countries do not make heavy use of this and other already available procedures, it seems likely that either they have relatively large family-size desires, or great ambivalence and no urgency about implementing desires for smaller families.

WILL FAMILY-SIZE DESIRES NATURALLY DECLINE

If people in most developing countries now want "too many" children for population stabilization, will this still hold true in coming decades, or will family-size desires "naturally" decline? In a monograph on incentives in population control (Pohlman, 1971), I have tried to look ahead at the factors that may be expected to lead people in coming decades actually to have fewer children than samples now say they want, and factors in the opposite direction. The picture seems dismal, and we may well see the continuation of desires for "too many" children.

As developing nations develop they should become like developed nations in wanting smaller families. But (1) the process of development is itself slowed substantially by failures to control population, so that without population control, development may be impossible; (2) development may be too slow to affect family size desires before it is "too late"; and (3) many developed nations, including the U.S., seem to want "too many" children, so that development by India (for example) to even the level of U.S. development would not automatically guarantee a solution.

Berelson (1966, 659) has described what I call a "delicious circle". As contraception is made available to eliminate unwanted births, actual births are therefore fewer. Seeing fewer actual births among their peers, parents then readjust their desires and community norms to match reality, then use contraception to eliminate even more births, and so on deliciously. This view assumes that not only do attitudes influence family size actions, but actions influence attitudes. Some test of Berelson's ideas should be provided in Taiwan. Means to limit family size are now readily available there and actual family size has dropped somewhat, presumably as unwanted births are less common. But new inroads on births and new acceptance of contraception have been discouragingly slow (Population Council, 1968), though more time is needed.

Perhaps population growth may make child-manufacturing more expensive, and housing scarcer, and hence may feed back "automatically" to lower family size. In Europe some patterns which might be fitted to this hypothesis are notable, but the hypothesis needs qualification and sharpening: people in Calcutta, Hong Kong and Rio may be very poor and crowded while still apparently wanting "too many" children. Perhaps only those who first have, and then see the possibility that they may lose what they have, fit the hypothesis.

We do not really know how many people can be fitted into the world or into a given country with reasonable comfort. Also, we now know how long it would take to get population growth stopped if we decided to go at it "all-out", or indeed whether it could be stopped. Either source of uncertainty would be disturbing; knowing neither where the tracks will go over the cliff, nor how long it takes to stop the train, makes a very uncertain predictive situation indeed. It does not seem safe to assume that family-size desires will naturally decline, and it seems well worthwhile to consider ways to try to manipulate and change these desires. One step toward doing this is to ask what causes family-size desires.

WHAT CAUSES FAMILY-SIZE DESIRES?

Scattered Hypotheses

We have a number of miscellaneous hypotheses about why people want larger or smaller families, many of them arising at the level of a common-sense type of psychology. For example, many people assume a "mother instinct". If there were such an instinct, we would probably have to believe either (1) that it would be fulfilled by having just one baby, or (2) that it would drive women on to an eighth child just as irresistably as to a third. Thus mother instinct thus would be of little help in explaining differences between desires for two-child and five-child families. If we are to draw parallels from non-human animals, we must note that some will eat or kill their own offspring. If humans have innate tendencies to parenthood, by the same reasoning they may have innate tendencies to kill their children. As Swift suggested, if we have too little food and too many babies, we could eat the babies.

The term "instinct" is a red flag to many psychologists, but if we speak instead of innate tendencies to motherhood, we may countenance the hypothesis that there are innate tendencies which make conception, pregnancy or delivery attractive. Just how the never-before-pregnant female body knows in anticipation that these joys await her would represent what we may call, with tongue in cheek, a conceptual problem. Possibly an innate attraction to sexual intercourse is all the innate explanatory variable we need, but I would define that as quite distinct from innate motherhood tendencies. It seems likely that if innate motherhood tendencies are involved, they are overshadowed and heavily moulded by learned factors.

Another example of hypotheses as to why people want children is the potency-virility-adult adequacy constellation of explanations. The father who proudly gives out cigars may be giving out tokens of his penis, according to some psychoanalytic thinking, and saying "I did it". Sex in the bedroom is a private matter but a big family is public proof that the man has been there successfully, at least according to one criterion of success. This is only one example of several psychoanalytic explanations offered for family-size desires.

When people in many countries are asked why they want large or small families, or why they favor or do not favor contraception, one common category of answers - often the most "popular" category - involves economic effects of babies. What people tell interviewers is not necessarily how they really feel. The economic costs of children are a "good" excuse for not having any more (in contrast to more "selfish" but possibly more true reasons, such as not wanting the noise and confusion or the responsibility and worries children make, or their interferences with mother's desire to be young and beautiful and go dancing more often). Despite this "discounting", what people say about economic reasons probably points to a very important area.

Economic reasons work in two directions. In India, children are often the only source of old age security in a country with no pension or social security system for most citizens. Asking people to forego a birth may be like asking Mr. Smith of Green Bay to tear up his social security card. Children are also expensive, and in industrialized societies it is primarily this liability that is noticed, whereas peasant societies are more likely to perceive children as economic assets. One study of Indian village parents suggested that they were sharply aware of the economic costs of rearing children, but made these sacrifices as a financial investment against old age; in this sense, "family planning" was hardly an innovation, for these parents *were* planning.

In five chapters of a recent book (Pohlman, 1969, Chaps. 4-8), I have reviewed the hypotheses commonly advanced as to why people want children, and will not carry on with this listing here.

Psychological research

Most of these ideas or hypotheses have not been tested and supported. Research is needed to understand better the causes of family-size desires, and psychologists are finally being attracted to research related to population and family planning. Instead of looking at scattered and isolated individual hypotheses about why people want children, or even at a comprehensive list of such hypotheses, we must develop ways of thinking about the *relative* importance of various factors, and their *inter-relationships*.

Trying to understand why births occur, psychologists will probably build "models". These are not like model airplanes, that merely copy something that can plainly be examined. Instead, psychologists cannot "see" clearly the abstract relationships they are studying. Their models are more like those early models of the solar system, built when scientists were still guessing how it worked, with little iron balls on wheels to show paths of planets. Psychologists' models are not in three dimensions, but in symbols on paper. A model is much simpler than real life, but selects a few simplified aspects of behavior because that is as much as we can manage at once. In the real world, the chains of causation, the causal networks, underlying a single event such as a human birth, are bewilderingly, blindingly complex and must be boiled down, abstracted, made into simplified generalizations. On the other hand, models integrating as many factors as reasonably possible seem advantageous, and computers make these more complex models easier to test.

One kind of model would see family-size desires as the blindly [illegible] effects of societal changes. Another kind of model might assume that societal changes are made up of individual factors, and hence might emphasize these individual factors. It is widely accepted in psychology that an explanation or an explanatory model is not intrinsically superior just because it uses a "larger" unit of explanation, or a "smaller" one. Births may be viewed as caused by physiological factors, or social change, or individual motivations; one "level" of explanation is as true and legitimate and accurate as another. Sophisticated psychological models of why births occur must include the inputs of biological factors on the one hand and cultural ones on the other.

Are Family-Size Desires Important?

One answer to the question of what causes changes in birth rates - one model of thinking about them - views births as mere puppets on the strings of broad social and economic changes. This brings us to the question of whether it is important even to worry about family-size desires. Suppose, for example, we know that if women go to work, they will have fewer babies; or that if there is more education or more industrialization, there will be fewer babies. If so, perhaps we can forget about "desires" or about trying to change them. Instead of trying to change individual motivation we simply work toward changing the social structure and functioning. Perhaps desires will simply follow suit and are only illusory epiphenomena, yanked along by social forces.

To illustrate, if we want to know why most Indian farmers do not own cars and American farmers do, there may be little point in asking farmers, or in looking to profound, subtle psychological motivations in the Indian farmer. Instead, we can study economic factors and changes in the nation. We can feel fairly confident that, if certain industrialization and economic changes occurred in India, most farmers would decide that they "desired" cars enough to get them, and we could forget about motivational analyses of why they desired them.

This illustration stacks the cards against psychology. There are some who are very pessimistic as to whether psychological variables can explain anything about why people have babies which cannot be explained at least as well by societal factors. Psychologists are late in arriving to work in the population field. Sociologists and demographers got there first and have bought up a lot of the available land and erected structures on it, and are not necessarily as friendly as they say they are to the arrival of newcomers. The available models to explain birth rates are primarily sociological and demographic models. Several studies have tried to correlate family size, or desired family size, with personality variables or other distinctively psychological variables. These attempts have not been successful. Psychologists tend to reply that the studies were designed primarily by sociologists anyway, and the instruments to measure psychological variables were not very good instruments.

Psychology should have its chance to develop models to explain births, and time must be allowed to tell whether psychology can make its contribution to population.

Even if absolutely no correlation existed between psychological variables and actual family size or the number of children people want, this would not mean that psychological variables did not influence people to have and want children. It might only mean that there were no *individual differences* in the way psychological variables worked in influencing people to have children. Statistically, if there is no variation in the X variable and no variation in the Y variable, there is no correlation. If the Y variable is the desire to have some children, rather than a larger or smaller number of children, we may have something like this situation statistically. To illustrate crudely, suppose we did a correlation between the number of men with whom a woman had sex relations during the month she got pregnant, and the number of babies born at birth - single, twin, triplets, and so on. Probably we would get a zero correlation, but this would not prove that sexual intercourse does not have a causal influence on births.

Prediction Versus Control

This brings us to what I regard as a very important point: that understanding something is not the same as controlling it. When the junior high school students start having intercourse, or the univerwity students start blowing up the buildings, we might be able to understand perfectly what causes their actions without being able to stop them. Psychologists are used to saying that if you can fully understand some behavior you can predict it in advance, and that prediction and control are opposite sides of the same coin. But while understanding and prediction may often be helpful in attempts to control behavior, the factors and explanations and models most useful and important in *understanding* bahavior may not be those most useful in *controlling* behavior.

Thus, even if societal variables were perfectly adequate explanations of birth rates, they might not tell us much about how to change birth rates. Knowing that Catholics or Mohammedans or poor people have higher birth rates may be interesting, but it is not usually possible to change people's religion or income in order to make them want fewer births. Even if individual variables in birth rates, such as motivation and family-size desires, were fully controlled by societal forces, individual desires might still be the best attack point to try to change birth rates. Waiting for industrialization, modernization and the like may be too long; we may need to move more quickly. My specific recommendation, to be developed below, is to offer financial or related material incentives to change family-size desires. This is an example of interfering at the individual level, and may work more effectively than intervention at a more societal level by promoting employment of women, modernization, and the like. Although the latter procedures may seem more "Natural", and might by-pass the nasty problem of consciously interfering with desires, they may be too slow.

HOW TO CHANGE FAMILY-SIZE DESIRES

Let us turn now to suggested ways of reducing birth rates. We shall classify these, arbitrarily, into harsh, gentle and intermediate approaches.

"Harsh" Approaches

Harsh approaches involve compulsion. Compulsion in the use of pills and condoms is impossible, short of stationing policemen to watch bedrooms. Many have discussed putting contraceptives in drinking water or spraying them from airplanes so that all would be sterile until they received antidotes. Psychologically this has the advantage of forcing parents to make a positive decision when they want a child - rather than, as at present, in order not to have one. But in addition to political difficulties in a program vastly more threatening than water fluoridization, the scientific details are not even on the drawing boards. Problems of broadcasting similar dosages to men and women, adolescents and adults, animals and people, and to those whose idiosyncratic medical condition made contraceptives unsuitable, are frightfully complex. What of people who drink four, not eight, glasses a day?

The only suitable vehicle for compulsion at present seems to be sterilization (since compulsory abortion or infanticide are even more objectionable). In the future, long-lasting contraceptive injections or implants might be coupled with compulsion, as might other new methods.

Society has a complete right to force limits on family size if large families are sufficiently dangerous to group well-being. In principle, this is no more of an imposition than rules against bigamy, incest, theft, cacophony, speeding, pollution, and so on. Curtailment of individual freedom by groups is scarcely new. But many societies have built up peculiar ideas about the sacredness of freedom to choose family size, which may make compulsion politically impossible for years to come.

We have gone from the Wright Brothers to the SST and the moon in two-thirds of a century, and have seen rapid change in some social patterns and attitudes, for example concerning abortion. It is not unthinkable that future decades will bring a general acceptance of compulsory sterilization after two or three children, in view of population problems. Males might be routinely sterilized shortly after puberty and after depositing adequate sperm in a bank. Psychological research on attitudes toward compulsion should be started immediately and would provide bench-marks for comparison of attitude changes over the coming decades - a point that also applies to many other areas of study. Nevertheless the "harsh" approaches are not only politically impossible just now, but seem risky bets even for the long range.

"Gentle" Approaches

"Gentle" approaches include education, information and propaganda campaigns; cutting infant mortality dramatically in poor countries so parents would no longer feel the need to have extra births to allow for possible deaths; discovering ways to preselect sex of offspring so parents would not need extra children in order to have the sons they want; popularizing adoption or childlessness; communal living patterns in which childless couples could be parent surrogates to the children of others; creating a social climate so favorable to small families that parents would feel deep shame to have three or four children (Pohlman 1966); and numerous other suggestions reviewed by Berelson (1969).

One major theme involves the roles of women; if they perceived important roles besides the wife, mother and homemaker role, they might want fewer children. Society might encourage and possibly subsidize education, training, and employment for women (including part-time employment), leadership, child care centers, avocational and recreational activities, etc. (Pohlman 1969, Cha. 7).

The major impact of these role-change programs would probably be in the middle class; one may wonder how effective they would be among lower class women in the U.S., let alone in developing countries. Also, one may wonder how _soon_ such schemes could be made to have significant impacts on the lower classes. Some of these role-change schemes might backfire; if fathers or child care centers take more of the child-rearing responsibility, this may merely free women from some of the confinement, drudgery and irritation that have probably been inhibitions to their wanting more children. The easy assumption that interest in work is in conflict with interest in motherhood is not always borne out.

On most of these "gentle" approaches, as on the "harsh" ones, psychological contributions could be substantial, especially research contributions to assess probable effectiveness. Doing research on all or most possibilities is the respectable, safe course; indeed, there is little choice if the profession is to act responsibly. Looking at everything systematically will also probably provide comfortable research support. It is sometimes said that more people live off of malaria than die from it, and some parallel witticism should be coined concerning population control. There remains in some minds, however, the disturbing suspicion that we are fighting a forest fire with teacups, and are forced to choose between the ineffective but politically acceptable approaches and the effective but tabooed ones. Are there intermediate approaches which are not as offensive as compulsory sterilization but could fairly quickly and effectively force action?

"Intermediate" Approaches

One of the popular images of the psychologist is that of the mastermind who can secretly press the hidden buttons of motivation and make people do what he wants. This mythical psychologist is perhaps a bit sinister, but powerful, dangerous and awesome. In view of population problems, I believe it would be perfectly ethical for psychologists to play this magic role vis-a-vis family size desires. My problem is not the ethics, but that I can't figure out how to do it like the magic psychologist should.

The one motivational button I can see involves material things. Men may be given a large cash payment for having a vasectomy. Or women may be given a hundred dollars for each three-month period during which they are not pregnant. Or, couples may get a large baby bonus and child allowance for each child up to the third - then lose all bonuses if they have more children. These suggestions are examples of incentives in population programs.

Incentives, half-way between "harsh" and "gentle" programs, involve some compulsion. Mrs. Pilpel stressed that we should emphasize voluntary programs and forget about compulsory methods at least for now.

But (1) if we are to have compulsory programs or at least incentive programs in future decades, we must start research on them now; and (2) we do not have a voluntary, laissez-faire situation now - only the illusion of a voluntary laissez-faire situation. Each child costs taxpayers thousands of dollars. Parents may buy the food and clothing, but taxpayers pay for the public schools, public health services, police and institutions, and so on. This is not even to mention "welfare" children who cost taxpayers much more per baby. Every non-welfare child, even, costs thousands. Thus, we have massive, though hidden, incentives already for large families! We do not have volunteerism in family size.

Huge rewards for years of non-pregnancy, sterilizations, or small families imply extrinsic motivation. The beautiful simplicity of intrinsic natural rainfall must sometimes be replaced with irrigation. Possibly three or four children are not crucially disadvantageous for individual families, and nothing that Madison Avenue or Women's Lib does can make it otherwise. Only an idealistic minority will sacrifice a wanted baby on the altar of population control, or perhaps even work hard to avoid half-wanted ones. We may find artificial, contrived, imposed, extrinsic rewards for population control necessary. We do not depend strictly on intrinsic motivation to get people to pay taxes, serve in the army, obey traffic laws, harvest wheat, pick up city garbage, or even conduct psychological reserach. What is so strange about rewarding people for their contributions to population control?

I have a monograph in press on incentives in population control (Pohlman 1971) and have been working for several years on the topic in India and here. Field experiments for poor families in the U.S. have been designed, packaged as the "Children's Opportunity Money and Environment" (COME) program. There are tremendous dangers and problems in incentives, which need study.

In closing, what we know about family-size desires is far outweighed by what we do not know. We do not know much about what causes them, what results from them, or how important they really are. Perhaps we can find out.

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Hospital Based Family Planning Services in an Urban Setting

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The topic to which I address myself today, as is indeed true of this entire symposium, is but a fragment of a much larger puzzle - the population problem - which, as the press reminds us, becomes more serious with each passing day, and by some is already considered hopelessly insoluble. There is indeed ample cause for gloom if one looks at the magnitude of the problem in relation to the efforts being made to find better answers or even to apply the knowledge we already possess.

Of the various themes which are played in explaining the hopelessness of the population crisis and our failure to deal with it effectively, one of the most recurrent is the ignorance of the natives. The planners sit high in their offices on the 34th floor of a skyscraper behind tinted windows and wonder why the stupid natives won't do what is good for them and stop having children. So then they decide that the solution of the problem lies in punishing the natives (negative incentives) or rewarding the natives (positive incentives) for contraceptive failure or success. The natives, meanwhile, are happily in bed enjoying themsleves, for which activity far more powerful positive incentives were devised eons ago, and the by-products of this activity continue to swell the population statistics.

Another popular theme is the inadequacy of birth control methods - that we need a longer lasting pill, a thinner condom, a better retained IUD, a slicker and quicker method of sterilization or abortion - then, at last, the natives will line up demanding the latest technical innovation and the population problem will magically melt away.

Reality is, of course, infinitely more complex than the researchers imagine, nor are the natives nearly as stupid as some social anthropologists have assumed. The key to population control is the provision of adequate information and services to the individual family unit. And the key to acceptance of birth control services in the family unit is the woman, for it is she who suffers the discomfort and inconvenience of pregnancy, the trials of labor, the mountain of dirty diapers, and the years of servitude thereafter which we collectively call motherhood. Few women are so stupid that they maliciously undertake to bring a child into the world for whom they cannot provide, nor is there any lack of excellent methods for preventing, spacing or terminating undesired pregnancies.

The confidence with which these assertions are made stems directly **from nearly a** decade of directing the family planning services at The Johns Hopkins Hospital, commencing in an era when the administration of the Hospital was so nervous about the activity that we could not list the Clinic in the Hospital directory or be officially assigned a telephone number. During those early years we worked like street walkers - everyone knew what corner to find us on and what our business was - but nobody wanted to admit that we existed.

The intervening years have brought many changes, including vastly improved birth control methods and recognition of family planning as a respectable and important medical activity. But what has really made the service significant has been the acceptance by the women of a full range of family planning services, based on the simple assumption that women - no matter how poor - no matter how undereducated - desire to regulate their family size and improve their life circumstances.

The Johns Hopkins Hospital sits on a hilltop about one mile from the central business district of Baltimore, planted in the middle of what it has become chic to call the East Baltimore Ghetto. The surrounding area, and most of the clientele, is black and poor. The choice of location and the population it serves is deliberate, as can be appreciated from the charge given the trustees in 1873 by Johns Hopkins in founding the institution. The trustees were instructed to receive "the indigent sick of this City and its environs, without regard to sex, age or color - and the poor of the City and State, of all races, who are stricken down by any casualty". The word casualty, according to Webster's Unabridged Dictionary can be defined as an unfortunate occurrence or chance accident, which certainly describes the main cause of pregnancy in our society.

In this setting, dealing largely with indigents who according to the folklore of the middle class were maliciously having babies in order to increase their welfare allotments, we began providing organized birth control services in 1962. There were no grants to be had from Federal sources because the Congress was concerned with the diseases of middle age. There was no City or State support for such programs because the politicians were concerned about possible repercussions from Catholics and charges of black genocide. A small private foundation - The Baker Fund - finally provided the means to hire a nurse whose function was simply to interview women after delivery and make them aware of the availability of effective birth control methods. In this small way, after a lapse of nearly a century, our Hospital began to treat the most common casualty in our patient population - accidental pregnancy.

Once this simple step had been taken - making sure that a full time nurse dedicated to disseminating family planning information contacted our female population - our contraceptive service began to grow by leaps and bounds. No leaflets, no posters, no coercion, no incentives, no audio-visual aids, no press releases or TV announcements - just woman-to-woman talk and the ready availability of methods for effectively preventing, spacing or terminating pregnancies. The effectiveness of the program may be gauged from the fact that ninety-six percent of all patients returning to our clinic after delivery participate in the family planning program.

What are the golden words which reach the unreachable and inspire the indigent to such an interest in birth control? Our clinic interview has been developed under the direction of the supervisory nurse, Mrs. Jean Fowler. It is a simple presentation, from which departues are made according to the questions from the women and the needs of the group:

Good morning - Im Mrs.__________ - and I'm here to talk to you about family planning. You're all back here today for your check-up. Now, everyone who has a pregnancy and comes for her check, we do talk to about birth control, or family planning. I'm here to advise you and tell you what is available in the way of birth control, so that if you don't want another pregnancy right away, you can get started on a good method of family planning right now.

The two best methods that are available today are birth control pills and intrauterine devices. And when I say the two best methods, what I mean is the two that are the most convenient and most effective. Quite honestly, nothing is one hundred percent perfect in the way of birth control. We wish it were, but it just isn't so. But the pills, if they are used properly and IUD's are both over ninety-nine percent effective. So that with either of those methods you can get almost complete protection. The failures with the other methods of birth control such as the diaphragm, the rubber or foam are much more frequent than with these two modern methods. But if any of you are interested in knowing more about the older methods or the rhythm system I'll be glad to explain them to you.

Now, when the pills came out about ten years ago, there was only one kind. Today, there are about twenty different kinds of pills available and they vary in dosage - they vary in the ingredients that are in them. What we do is use the lowest dose pill which has been found effective. The lowest dose pills have been found to be the safest type of pill, because they disturb your own body system the least. It's important that you take one pill each day. Not two today and none tomorrow. They just don't work well that way, you must take them as they are prescribed. Now, when you get to the end of your package of pills, you will have your next period. Then, you start your pills all over again. You do this every month over and over as long as you don't want to get pregnant.

You may have heard that the pill can be harmful to some women, and that is true. There are some women who cannot take birth control pills at all for medical reasons. Some of the people who are advised not to take the pill are women who have had any kind of history of blood clotting in the past. That's because the pill has been shown to cause changes in the blood. Very often women who are diabetic or have trouble with asthma are advised not to take the pill. Women who have had any history of breast tumors are usually told not to take the pill. We'll check your history and the doctor will examine you before you start. So some women have to be ruled out right away as pill patients, they just aren't good candidates for birth control pills, Sometimes, though, a lady who seems perfectly healthy starts to take the pill and she'll develop what we call side effects. She may have some nausea or morning sickness. Or she may have some headaches. Or she may get pains in the legs or chest or have blurred eyesight. She may have just some kind of vague feeling of uneasiness.

Now I would suggest this to you: If you start on pills and you don't feel quite right - whether you've got headaches or you're nauseated or have pains in your legs - please report that to your doctor or to your clinic. Most often if you stay on the pills for a couple of months minor complaints such as nausea will disappear and you can go on with your pills. But it is important to report symptoms to your doctor or your clinic because once in a while we'll find a woman with whom the pills don't agree and she may get into more serious difficulty if she tries to stay on the pill. So always take the pills under the care of a doctor or clinic.

Now, have you got any questions about pills, anything at all that I didn't cover that you might like to know about the pill? One question that most people ask about pills is what makes them work. I'll tell you briefly about this. You all know that you have a period every month. In between your periods, while you're not aware of it, there are other things that are happening. And one thing that happens, usually about midway between your menstrual periods, is that you ovulate. Now what this means is your ovary releases an egg. If you have relations at that time and the sperm meets with the egg, you can become pregnant. What the pill is all about is it prevents your ovary from releasing eggs. As long as you take the pill correctly, you stop producing eggs. Therefore, since there is no egg, pregnancy is prevented. That's why it's so important, if you take pills, to take one pill each day, because any day that you miss a pill, there is a chance you might ovulate.

Now, here's what to do if you miss a pill - say you're taking them at supper time each day and one day you're not home for supper and you don't have your pills with you. If that happens, take that pill as soon as you get home, or take it even the next morning if you forget it that night, but then get right back on your regular schedule. The problem with pills, as far as women getting pregnant, is usually the woman's failure to take the pill correctly. If you have trouble remembering medicines, it might not be the best method for you. But if you can take the pills on schedule, it is one of the best birth control methods ever developed.

The next method of birth control I'd like you to know about is the intrauterine device. Most IUD's are made of plastic, although some have been made of stainless steel. The IUD is different from the pill and most other birth control methods because it works without any extra effort on your part. IUD's are inserted by a doctor, usually while you are having a menstrual period or right after your period ends. For two reasons: first of all, if a lady comes to us with her period, we know she isn't pregnant and this is important; secondly, your cervix, which is the mouth or neck of your womb, opens up a little wider when you're having a menstrual period and that makes it easy to slip the device into the uterus.

What the doctor does is use an inserter, which is a thin rod-like affair, to slip the device through the mouth of the womb, and right up into the hollow part of the uterus. Once the device is inside, he takes the inserter out and the IUD nestles inside of the uterus. A threadlike tail of soft plastic dangles through the cervix as a marker. It won't bother you or your partner. The tail is helpful when you come back for a follow-up visit, so we can look inside to see the string coming through, and know the device is O.K.

There are some side-effects from the IUD also. After insertion you may find that your periods for the first couple of months are a little longer than usual or your flow may be a bit heavier. Some women also spot or have some staining in between their periods in the first couple of months. Not everyone does this, but a lot of girls do and we find it's better to tell you you might bleed a little more or spot a bit than to have you get an IUD and go home and start bleeding and not know why and be worried about it. It usually will settle down, but it may take your uterus about two months to get accustomed to having the device inside. Now, even though you're having a period and probably won't have relations immediately when it's put in, your protection starts right away. With an IUD if you like to wear tampons that's fine. It will not bother the device which is high up in the uterus. If you like to take douches, fine, that's not going to bother the device either.

I mentioned bleeding or spotting as a side effect of the IUD. There's another problem - expulsion - which used to be common, but is rare today with modern devices. Each month when you're having a period, check your pad or tampon each time you change before you throw it away. Because if an IUD is going to come out, it probably is going to happen when you are having a period, when your cervix is open. The modern IUD is really very safe because it is retained perfectly by ninety-nine percent of women and provides a ninety-nine percent protection against pregnancy. The reason many women like the IUD is the protection is so natural. It works inside the uterus, so there is nothing for you to take or remember, nothing extra you must do before relations. Because it works inside the uterus, the IUD cannot change your natural hormone balance.

The device can be left in for months or years, as long as you don't want any more children. A lot of women use this to space their pregnancies. You may have had a baby this year and maybe you don't want a baby for two more years. So you can have your IUD until you're ready to plan your next pregnancy and then when you want to get pregnant again, call us while you're having your period and let us take it out.

I also would say that if you get an IUD - and this is a thing that you are choosing yourself, whether you choose pills or IUD or whatever kind of birth control you want - it's your privilege if you don't like the method for some reason - any reason at all, you can certainly switch to another type of birth control. Once you get an IUD doesn't mean you're stuck with it forever, and if you find the pills don't agree with you, you can change. We do find that most girls, once they get though the first two months, are very pleased with the safety and security of both methods.

The first few weeks are important - you have to get used to taking the pill and you have to get used to wearing the IUD. After that, it's pretty smooth sailing for most women using either of these modern birth control methods.

There is another type of birth control which some of you may want to think about, which is different from the other methods because it is really permanent. Yet it accomplishes the same thing - keeps you from getting pregnant - with even greater security than either the IUD or the pill. That's permanent birth control by sterilization or having the tubes tied. If you are sure you already have all the children you want, and feel certain you'll never want to be pregnant again, then you should know about this method.

Having the tubes tied keeps you from getting pregnant by keeping the egg from reaching the uterus. Your regular periods continue and the egg is released every month, but since the tube is blocked, the egg dissolves without reaching the uterus and pregnancy is prevented. Today having the tubes tied can be done very rapidly - it takes about twenty minutes and most women don't have to spend more than one day in the hospital. So if you feel your family is complete, and you are not interested in the other birth control methods, ask the doctor about having your tubes tied. Many women have had this done and find it more convenient than other birth control methods once their family is complete.

You will be examined today by the doctor before starting birth control. After that what we do in the way of follow-up with birth control is to bring you back in about eight weeks. What that does usually is let you have a period and by observing how much bleeding you had and how you are feeling, we can get a pretty good idea whether or not everything is settling down as it should. If everything is ok at that six weeks check-up, then we ask you to come back again in six months. We'll be doing pap smears on you and keeping track of you whether you're on the pill or IUD. Naturally, if you have any special problems, we can see you in between your check-ups.

Now, unless you have further questions, you can each decide what type of birth control you want before the doctor examines you. I'll be seeing you again before you go to make sure you understand everything and have your appointments arranged. I'll have to get some information from you now. Mrs. ______, what sort of birth control are you interested in having?

The response to this approach to providing family planning services has been most rewarding. Offered a range of options, it is interesting to observe the methods which our patient population selects:

ACCEPTANCE OF CONTRACEPTION
AND STERILIZATION POST-PARTUM

Method	Percent
IUD	53
Pill	25
Sterilization	16
Other	1
Acceptors	95%

With respect to most clinics, these figures differ in that we have an exceedingly high degree of acceptance, and this I ascribe entirely to the charm of my nursing staff. Only one patient in twenty leaves the clinic without some method of birth control. The figures also differ with respect to the choice of methods - we have a high rate of acceptance of intrauterine devices and a high rate of surgical sterilization in relation to most clinics.

Actually, I do not think that either of these rates are out of line. We are using sophisticated intrauterine devices in our patient population which are well retained, extremely convenient and highly effective. The woman-to-woman grapevine in our patient population transmits the fact that intrauterine devices are an excellent birth control method, so that a high proportion of our patients select the IUD as their first choice method.

The relatively high proportion of women selecting surgical sterilization in our clinic is also, I believe, a measure of the needs and desires of the female population being served. An acceptance rate of nearly twenty per cent simply reflects the fact that every fifth woman delivering a baby at our hospital has achieved her desired family size and is more interested in permanently terminating her reproductive career than in using temporary birth control methods such as the pill or the IUD.

Our female population is also aware of the fact that our methods of sterilization are extremely convenient and effective. The procedure used to require four or five days in the hospital and a four or five inch incision. The majority of our sterilizations today are done by a technique called laparoscopy, which can be carried out in twenty minutes through a tiny puncture just beneath the umbilicus.

The laparoscope is an optical instrument for visualizing the tubes which are essential to carry the eggs from the ovary to the uterus. Under a light anesthetic, the instrument (which is about the diameter of a fountain pen) is introduced through the abdominal wall, the tubes are identified, and by means of a cauterizing electric current, the tubes are interrupted. Discomfort following this type of sterilization is minimal - the patient usually goes home the same day and is able to resume full activity the following day. By means of this technique, sterilization in the female has been made simple, economical and exceedingly convenient, and the acceptance in our patients is a testimonial to the ready availability and effectiveness of the procedure.

The moral of my story, in case you haven't already guessed it, is that the natives are not so stupid and the family planners are not so smart as some have thought. Most hospitals, urban or otherwise, do not have an effective staff providing contraceptive services. Under the circumstances, it is not surprising that we are not serving the public more effectively.

In fields unrelated to reproduction, a remarkably broad range of specialized services can be obtained. Most hospitals of any consequence maintain counseling services covering nearly every conceivable area from mental health to dental health. Most teaching institutions of any pretentions can provide you simultaneously with a speech therapist to cure your stutter as well as a dietitian to advise you on butter. But if the problem is a desire for first class birth control services, more often than not the staffing is inadequate to meet the needs of the public. Even institutions with very large maternity services often lack anyone charged with the responsibility of supplying women with birth control information.

And even when some information or services are available, the range of services is frequently limited by archaic laws or hospital policy. If a woman wants a hump removed from her nose or a bump removed from her breast, surgery will be swift and certain. But if she wants an undesired pregnancy terminated, the continuity of her tubes interrupted or access to simple birth control methods such as the IUD, diaphragm or pill, the institution often will not or cannot provide the service. Yet unwanted pregnancy is the most common affliction of women, and the fruits of such archaic laws and policies are everywhere to be seen in the form of illegitimate pregnancies, illegal abortions and children born into a family structure strained by the consequences of excessive reproduction.

If our experience in providing birth control services in an urban hospital setting during the past decade has any meaning, it is that women - irrespective of race, color or educational level - are intensely interested in utilizing effective birth control methods, and do so with enthusiasm when services truly suited to their needs are provided. The concept that the public is incorrigibly stupid, animal-like and incapable of utilizing effective birth control methods is nonsense. Far greater impediments to the provision of services exist in stupid laws, stupid hospital policies and a stupid lack of organization to meet the needs of the public in the field of fertility control.

Leadership by Federal officialdom in provision of adequate family planning services was virtually non-existent throughout the 1950's and 1960's, while the population crises in the U.S. and abroad was becoming increasingly unmanageable. As late as 1970, only forty-eight people in the vast bureaucracy of the U.S. Agency for International Development were working on population problems. For 1968, the budget of the Department of Health, Education and Welfare exceeded thirteen billion dollars, of which the fraction apportion to population problems was less than one quarter of one percent.

The U.S. Congress has been preoccupied with the diseases of middle age, and the budgets of the National Institutes of Health have reflected this preoccupation: As of 1969, this agency expended one hundred eighty-five million dollars for cancer, one hundred sixty-five million for heart dieases, and 10.8 million on research directly or indirectly related to reproductive biology. Even the budget for research in allergies exceeded by ten-fold the N.I.H. investment in birth control. Paul Ehrlich (2) succinctly described the scandalous state of affairs in 1968: "What is the Government of the United States doing in the area of population control? It is bailing the sinking ship with a very small and leaky thimble."

Hopefully, more enlightened policies will be forthcoming in response to public pressure at the local, state and federal levels. Women are increasingly making themselves heard in public life, and are asserting their right to have the number of children they want when they want them. Acceptance of the concept that the woman, rather than the state has primary title to her own fallopian tubes would represent a major advance in implementing effective population control.

At the Federal level, a hopeful sign has recently appeared in the appointment of Dr. Louis Hellman as Deputy Assistant Secretary in H.E.W. in charge of population affairs. This distinguished physician has a long history of activism in the field of contraception, and if his office is given adequate funding and authority, we may see serious support for birth control services at the national level for the first time.

While we are hoping, we can also hope that improved methods of sterilization, abortion and birth control will become more widely available, and that methods yet undreamed of will be forthcoming from the research laboratories.

In the meantime, to flame the inadequacies of present methods or the inadequacies of human motivation for our slow rate of progress is to ignore the successes already achieved when adequate efforts to provide contraceptive services have been made.

Our experience certainly indicates that if current techniques are exploited to the fullest extent, and family planning is supported as serious service activity, the public is more than ready to accept contraception. To meet the unmet need for fertility control we must bridge the gap between contraceptive technology and lack of organized delivery of services. It is not enough to have good methods, we must see that the methods are effectively used. If the population crisis is to be solved, we must pursue this objective with the same vigor we attach to collecting moon rocks. The development of practical service programs to deliver contraception locally, nationally and internationally is the major challenge facing civilized man in the next decade.

Panel Discussion

DR. SANDMIRE:

The panel will be prepared to discuss any question from the audience. Please direct your question to the panel member you wish to respond, and also before asking the question, please wait until the microphone is before you in order that your question can be recorded.

In addition, I thought it was helpful yesterday when the questioner identified himself by name and background and area of interest. Therefore, we will continue that practice. The panel members, most of whom are well known to you, have made formal presentation so far except for three additional members. On my far left, is Dr. Jeremy Green, a physician at the Webster Clinic, a specialist in internal medicine, who has been, in my opinion, a bright light in Green Bay medical circles; and next to him is Dr. Thea Sager, who is on the faculty, as a lecturer, in the College of Human Biology, and holds a Ph.D. degree in physiology and embryology. Adjacent to Dr. Sager is Dr. Edward Pohlman, whom you know. On my immediate right is Dr. Hugh Davis; and then Mrs. Evelyn Farrell, who is a UWGB student in the College of Human Biology with a concentration in population dynamics; and then on my far right is Dr. James Crow. Most of you heard his presentation last night; it was very well received: he is Chairman of the Department of Medical Genetics at the University of Wisconsin Medical School in Madison.

Without taking up any further time, we will open the session to questions from the audience.

BOB LOPEZ (UWGB student):

Dr. Pohlman, yesterday Mrs. Pilpel seemed to indicate that the laws regarding abortion would be declared unconstitutional because it invaded the privacy of the individual in regard to reproduction. I was wondering how this unconstitutionality might affect compulsory incentives in the future, in regards to tax incentives, or whatever?

DR. POHLMAN:

I think it is very ironic historically to think that we are almost having a pendulum swing in the thinking of some nuts like myself from the extreme of saying that we ought to prevent people from having free will in the area of abortion and contraception - we should keep them from having as few as they want - to saying let's have freedom of choice, and then to the opposite extreme (not to have children). My response would be to say that we have a tremendous invasion of freedom already in so many spheres of life. We have many fine Amish families that don't really want to send their children to school, but they are forced to do so - an invasion of privacy. I couldn't have two wives if I wanted to - even if they would both consent (which is impossible - I had enough time getting the one to consent). We have this tremendous invasion of privacy because of the needs of the group, and my interpretation is that if things become desperate, and it seems to be to the advantage of the group to put pressure on people to limit family size, if we eventually get hungry enough, I think we are going to revise our thinking about constitutionality and laws.

ANTON STEFFEK (Senior at Southwest High School):

I began an ecology club known as "Students' Environmental Awareness Committee" at school and my major is analytical and organic chemistry, and my question is for Dr. Crow.

With the developments in genetics and related fields of biology, especially with the synthesis of a gene which could possibly lead to the formation of a person in a test tube, as a manner of speaking, what effect would this have on the birth rate in the world, or, specifically, in the United States because this is where the research is being done.

DR. CROW:

I would predict that it wouldn't have very much effect on the world birth rate, but I emphasized last night, and repeat now, that we are a long way from any such thing as you are suggesting. The synthesis of a gene is an amazing and wonderful achievement and undoubtedly this will have important practical application in medicine and ultimately at the population level, but I think it is too far in the future for me to make any reasonable predictions now.

HENRY KREBS (Division of Health, Madison):

Dr. Davis, as a demographer, I am concerned about the reproductive outcome of programs of contraception, etc. I am wondering if you have any measures of the impact of your program on the fertility performance in the community in Baltimore, either in terms of period fertility rates or in terms of attenuation of spacing, or something of that kind?

DR. DAVIS:

We do not have data that would be satisfactory of the kind that you express. Nevertheless, a good measure of this kind of thing is in terms of continuation rates for a particular method. We have continuation rates with sterilization procedures which are virtually one hundred percent, and this is unquestionably four or five times more effective than temporary spacing methods. One twenty minute visit is twenty years of fertility regulation. So, I don't think we have to look up individual cases to know what the failure rates are - one thousand, something of that order.

We also have data on abortions, but they again are not expressed in terms of population figures that would be of a precise nature, speaking as a demographer. The continuation rates with the newer intrauterine devices for one year are in the order of ninety-five percent; whereas with the older types of IUD's, it used to be seventy-seven percent, so there has been improvement in this area; and the majority of women who discontinue one method do indeed take up an alternate method.

With pills we do not do that well in a relatively young, and relatively poorly motivated population. We finished the twelve month period with about fifty percent of the women continuing, and with about half who have discontinued pregnant. So that from a clinical point of view, we wind up about twenty pregnancies for every one hundred women who start on oral contraceptives. This would be quite different from a private practice situation where you would have better returns and better compliance. Demographically meaningful figures may come out of the National Center that is being established.

DR. SANDMIRE:

Dr. Davis, when you listed the percent of acceptors, this was the percent of those patients returning for their post-partum examination, is that correct?

DR. DAVIS:

Yes.

DR. SANDMIRE:

Did you have any figures on what percent of patients failed to return for their post-partum examination?

DR. DAVIS:

Yes, I can give you a before and after figure which on patient return after delivery at six weeks was running in the neighborhood of about forty percent before we started providing birth control services and since we started this program, which now dates back some years, the return rate from our catchment area is running seventy-five to eighty percent.

DR. SANDMIRE:

What Dr. Davis is saying is that provision of family planning services resulted in more women returning for a check-up, which they should have for health reasons. So this has been a way of improving the return rate in his hospital. Originally, I neglected to have our new panel members have the opportunity of making some brief statement or comment if they have any to make. I would like to ask Dr. Thea Sager to say anything that she might wish to so that you might get to know her and direct questions to all of our panelists, rather than those you know better by virtue of having listened to them.

DR. THEA SAGER:

Perhaps I would most like to emphasize the fact that we have heard in the past two days a great deal about making accessible to all the population the various services of contraception, sterilization and abortion; that this would involve more money, changes in laws, education of the population in terms of the services available, and in terms of population growth and better organization of the services. But assuming that all of these services are made available to a large number of the population, or to all of the population who want them, so that unwanted pregnancies or conceptions are reduced, does this mean that we will have population stabilization. It would seem, as Dr. Pohlman suggested, that we must also take into consideration and emphasize the effect that attitudes and motivations of individuals have in making use of contraceptive devices, or abortion services. What about the attitude of the individuals who want to have three, four and five children because they can support them; because they can give them love; because Brown County isn't overcrowded; what about the attitude of the individuals who have access to birth control, have planned their families, have completed their family, but sort of hope and pray that they don't have any more children; yet wouldn't have an abortion and don't take the necessary measures to make sure that they will not have any more children. It gets into the problem, as I said, of what motivates individuals to have children, their desire for family size, etc., as Dr. Pohlman mentioned. I wonder how many of the students here are seriously considering an alternative to marriage; or are seriously considering postponement of marriage; or are seriously considering - the women or the ladies - carrying on a vocation outside of marriage, being married but having a vocation. Just as important, how many of the gentlemen are willing to accept the fact that their wives may want to have a vocation outside of marriage, and are not willing to spend all day, every day, at home. How many are willing to have one child or try for two and adopt the remainder. I think, as I say, we must stress motivation as well as accessibility of information and devices.

DR. SANDMIRE:

Thank you very much. I would like to interject at this point too that what she is talking about is attitudes, and Dr. Pohlman is going to be responsible for me losing a little sleep in something that he said. There are two reasons why I will have a sleepless night. He said that if the voluntarism results in a lower number of children, this might be the in thing and it might be contagious, and what would this be called - a "herd instinct" perhaps. And it's going to result in sleeplessness, because this is intriguing, I am excited about this; and also sorry that I hadn't thought of it myself. Anyway, this relates to attitudes. In other words, reduction of the number of children to the wanted level, as Dr. Pohlman said, may reduce the number wanted. Do you have any more comments on that at this point?

DR. POHLMAN:

I will send you a reprint of a 1966 paper called "Mobilizing Social Pressure to Reduce Family Size" where the thesis is developed. The problem is how to get it started. As long as I have the mike here, I want to say another thing that I have been kind of wondering whether to say this whole time. And that is: in a church service it's sometimes good to hear an agnostic or aetheist - not that you necessarily believe what he says. I hope that all of you who are active in ZPG and have what I sometimes call "Ehrlichian kinds of thinking", have had some exposure to the very enlightened articles that have recently come out pushing the other point of view. There are half a dozen or more excellent ones which I have discussed with many of you, and you are already familiar with them, but I would hope that as a University community your classes don't become so one-sided, either one way or the other, that you see just the one side of the question. Frankly, as I was saying over drinks at midnight last night, I am really confused as to how urgent the population crisis is, particularly in this country. I listen to Paul Ehrlich and I am impressed and frightened; and on the other hand, I listen to these people, including the former president of the Population Association of America, the former president of the Population Council, Dr. Donald Bogue, down at Chicago, and others, and I say "jeez, these are not nuts, they are not even Catholics", even though they sound like it. And Bogue has an article "The End of the Population Explosion". I hope you will look at both sides. Excuse me for that.

DR. SANDMIRE:

Thank you so much. And now, Dr. Jeremy Green, do you have anything that you want to share with us?

DR. GREEN:

I have two questions I should like to ask, rather than make a statement. One question I would like to direct to Dr. Pohlman and the other to the audience. This one is addressed to Dr. Pohlman.

I would be interested to know if he is aware of any studies showing the psychological effects of having had an abortion. One hears of women with self-reproach and even suicidal thoughts, but my belief is that is not so and I would be interested to know from Dr. Pohlman if he knows of this.

The other question might be directed to the audience. What has struck me about this symposium and the one a year ago is that if we had to listen to comments as I have in the past two days, one would think Green Bay to be one of the more liberal towns in the country. There has been no argument and little discussion on what has been said - we have all esentially agreed. This is not my experience as a physician. Not only do I find the community conservative, I find the physicians in general ultra-conservative. And I just wonder whether there is anybody in the audience - I certainly don't want to put anybody on the spot - but whether is anybody in the audience who has something to make me change my views and my opinions about these questions. I was just thinking that ten, fifteen or maybe fifty years ago, what we are saying here would have been heresy and we would probably have been the ones who would have been silent had we been sitting in the audience. The role seems much reversed now. I would really like to know whether there is anybody in the audience who has some other ideas or some difference of opinion. I would be most interested in answering questions.

DR. SANDMIRE:

While you are organizing your lecture for Dr. Green, we will go to Mrs. Evelyn Farrell, and see what her comments would be.

MRS. EVELYN FARRELL:

Before I came to this school I lived in Maine, and we didn't have any population problems. There isn't anybody there. I went home at Christmas time and I thought these people don't care about any population problem. You go for ten miles and you might see ten houses. They have no idea that there is anything wrong anywhere. When you get into Green Bay, I found that because of the pollution and a lot of people around, there is a problem. But they don't know and somehow you have to get to them too, because they have five and six kids. It all deals with education, I guess.

DR. SANDMIRE:

Thank you. Now, we will reopen the questions from the audience.

DR. POHLMAN:

May I answer the question that Dr. Green raised?

DR. SANDMIRE:

Yes, you may.

DR. POHLMAN:

I would like to join him in inviting those who hold different points of view to speak up, give comments and ask questions. I think it is very possible to become restricted and doctrinaire in our liberalism about many of these things. Concerning the question that he (Dr. Green) addressed to me, while we have a number of dogmas about abortion that need to be scrutinized with research, one dogma that has been around for years is that it's medically, intrinsically a very dangerous operation. As you were told yesterday, and as all of the research certainly confirms, this is not true.

Another dogma that's around concerning abortion is that it keeps you from having conception later on. There is not a shred of evidence to date -scientific evidence - to support this, even though there are some minor studies that have, as I see it, been misinterpreted in this direction.

Another dogma that I think probably has a little more support is that abortion leads to prematurity in future conceptions.

Another dogma is the opposite: if you have an abortion you will have another child anyway. How can you argue that it's going to make you sterile and also that it's going to make you have another child.

Now, in the particular point you have asked of me - psychiatric effects. The literature on this is in a preliminary stage; there is no evidence for the dogma that there is widespread guilt and upheaval as the result of abortion. I think we can hypothesize that this will vary with the culture. People living in a culture that is very accepting of abortion are not going to feel guilty about doing it, and certainly this is true in Japan, where abortion for centuries has been unopposed by the religious philosophy. This is true in Eastern Europe. We don't expect guilt - we don't have it. Scandinavia is in an intermediate position, and there we have the most extensive studies that there are. I think that the study by Ekblad, even though it has many limitations, is probably the most extensive one. From several hundred cases, he concluded that, in general, psychiatric problems were of a very minor nature. You have to compare the psychiatric problems of abortion with the psychiatric problems that result if you don't have an abortion and you have post-partum psychiatric problems. This is true all along the line. The problems of abortion must be compared with the problems of having the baby. In this country we have had this stereotype that you feel terribly guilty, you feel terribly upset, this varies with how the physician handles it, for example, if he makes the women feel that it is a terrible thing. It varies with the cultural attitudes. I'm guessing - if it's legalized and more legitimated then you don't feel so guilty about it. I have sent girls to Mexico. They have to sneak down there furtively to get an abortion, and I am sure that if you have to do it surreptitiously you feel more guilty about it. We just don't have any evidence suggesting widespread guilt and upheaval as the result of abortion.

DR. SANDMIRE:

I think that's an excellent response to that question.

PAUL JOHNSON (Southwest High School):

I have a question for Dr. Green. I wonder if a program such as Dr. Davis' could ever be implemented in Green Bay with the highly Catholic and conservative point of view from this town?

DR. GREEN:

If I may, I would like to refer that to Dr. Sandmire who really, I think, would be much more instrumental in being involved in such a program because being an internist it is easy for me to sit here and project my beliefs, but I don't do these things. Herb, maybe you can answer that question.

DR. SANDMIRE:

Dr. Davis' program is an excellent program of providing family planning services to women at the six weeks' checkup following delivery, or perhaps abortion, spontaneous or induced. This is an excellent program and we are right now in the process of trying to determine whether all Green Bay women who deliver babies have available to them at the six weeks' checkup family planning services. With the help of Dr. Baker and Dr. Beaton, we have developed a survey questionnaire, and we hope to have this questionnaire filled out by a sample of Brown County women, which will then enable us to answer your question with hard information - at least more than I have now. My impression is that the majority of women in Brown County do have access to family planning at the time of their six weeks' checkup. They may not all have, because of physician preference, access to an intrauterine device, or surgical sterilization.

However, I think it would probably be a rare occasion regardless of the religious affiliation of the physician or patient that she would not have the option of taking the pill. Now, if the patient desired some other method, then it would be hoped that she would know that she could obtain this from another physician if her own physician did not provide that service. This I can't answer for sure.

DR. ANDREW KRAPOHL (Physician, Marinette, Wisconsin):

I would like to present a question to the audience and anybody on the panel. I read the proceedings of this meeting last year, and a Dr. Pion at that time indicated that medical people bend backward in implementing programs. Dr. Sandmire's reply was that in general medical people have been responsive to what the public needs.

Since one year ago, the State of Wisconsin Medical Association has verbally voted for abortion on demand - if you want to describe it that way. There are now two abortion services in Madison for anyone who wishes to take advantage of those services. Things can be accomplished both in Green Bay and my own community; sterilization is wide open in both these communities. And in one year the medical communities have responded to the demands of the public.

The big problem I see, as a practitioner in Marinette - I couldn't set up a service like Dr. Davis' I am sure; and I haven't done the tubal ligations he has done - we still do them the old fashioned way. But my girls that I see don't know what missed menstrual periods mean. And when I talked to our high school counselor, I had to remind her twice that I was talking to her about abortion and not about delivery. When are the educators, and when are the people in the communities, going to respond and make educational tools available and use the most effective thing, and they develop these points. I think medicine in this area has responded and now let's see if some of the people in the communities can respond and run the gap of community flack.

I am now called Dr. Curet by members of my staff. My little girl comes home and says: "my friends tell me you kill babies". These are the kinds of things physicians are exposed to. When is somebody going to say on a school board "I'm for sex education in the schools". When is a biology teacher in school going to start talking about sex, even though they may lose their job. I think some of these things you are going to have to be aggressive with if you are going to make progress and challenge the people that say they are against them and see if they will really accept the challenge and force it.

DR. SANDMIRE:

Very excellent, I would have to agree, being in the same vocation as Dr. Krapohl. Now, did Mrs. Krapohl have the same question, or a different one.

MRS. KRAPOHL:

There is a national - international - LaLeche League that is known, I think, by most women, most physicians. And some of their literature they produce, and I know Mrs. Kullerstrand is here, who is more active in it than I am. They talk about breast feeding, helping to space babies, and such, and I think it's gone as far from their medical advisory committee, that if a baby is nursed completely, and no solids, nothing added, just completely nursed, that this is a fairly good method of contraception. I have real feeling about this, and I wonder if these groups in getting to this group in Chicago - the international group - what do the physicians have to say who work with women - who see women who are nursing their babies. Do you agree with this? Is there an alternative along with breast feeding? Should these women be cautioned that there should be some other method used? I think that this is part of educating the public and many of the people here are students. They will be thinking of reproduction and pregnancy and how they are going to feed their babies, and such.

DR. SANDMIRE:

I think breast feeding is good for those who want it. But I don't think it's an effective method of birth control and I don't think it should be relied on by an individual woman who is serious about wanting to avoid pregnancy.

Regarding Dr. Krapohl's other comment and his nickname Dr. Curet, it hasn't been quite that bad although I did have a sticker in my hospital box which states that "Abortion is Murder" in case I wanted to put it on my car.

MRS. BEA KABLER (Chairman, Wisconsin Citizens for Family Planning):

I am going to talk about something else though instead of political action this time. I am concerned about quality of care. That as we begin to develop clinics and services in Wisconsin - we are at the beginning stages in so many communities around the State - can any of you give me an opinion as to the quality of care - comparing a clinic such as Planned Parenthood - that is set up to serve everyone who comes on the basis of their ability to pay. Compare that to the clinic which is set up only under O.E.O. auspices and serve only that level of income which falls under their guidelines of $3,000, etc. per family. I am questioning this myself and I am wondering if any of you have any experience to draw on as to the quality of care. I feel that if our first efforts in Wisconsin don't show really good results, it will be difficult to try to begin again after something has fallen through and not proven to be successful and accepted in the community for whatever reason. Perhaps this should be directed to Dr. Davis, or anyone else who has an opinion?

DR. SANDMIRE:

Let's let Dr. Davis respond first and then if others do have an opinion, they can comment.

DR. DAVIS:

That's a very broad and perceptive question. One can look at the services that are provided by Planned Parenthood or by O.E.O. clinics, or by hospitals and find a considerable variation as one goes from place to place. We had not only battles with people who are against birth control, but internal problems of trying to decide what should be delivered as part of a service package.

I, for one, think that you can't have a second class service. That is to say, if a clinic undertakes to begin to see women on a regular basis repititively, that clinic, like it or not, has to develop some reasonable preventive health measures. The clinic will need to be following her blood pressure and taking her pap smears. The pap smear taken in connection with the birth control program is extremely important. For the first time we have gotten women to come; they have come because they wanted birth control and they had pap smears taken on a repetitive basis. These populations are not getting cancer of the cervix which is a highly curable, highly preventible disease. The same thing can be said for the taking of routine cultures for venereal disease. We have an epidemic of venereal disease going on in the teenage population in this country and one of the roles of a clinic has to be the taking of cultures, the identification of carriers, and making arrangements for appropriate therapy. In the beginning, many clinics started out essentially as pill clinics on a street corner, with wholly inadequate medical surveillance and preventive medical components. That is changing. It must change. We should strive to eliminate the disparities in the level and quality of services that have existed in some programs.

DR. SANDMIRE:

Dr. Crow, would you like to comment on the question?

DR. CROW:

I would like to comment, but it's not on this particular question so let me wait until later.

DR. SANDMIRE:

All right. Does any other panel member wish to respond to Mrs. Kebler's question? Then, Dr. Crow proceed.

DR. CROW:

What I was going to say was in answer to a question raised several minutes ago. This is whether there is other responsible opposition to the birth control movement that ought to be answered. I think there is.

Many of you have probably read in the newspapers of a discussion that took place in the American Association for the Advancement of Science meeting in Chicago a week ago. On that occasion Paul Ehrlich gave his usual talk. Garrett Hardin joined him, and then Barry Commoner, who is an environmentalist, simply said this is a cop-out. (It was his expression; I am not sure of what he means by it). He said that when you view the problem of pollution, the real problem isn't the number of people, it's the way that they use energy. He said, if I understand correctly, that the population people, such as all of us seem to be, are directing ourselves to the wrong question. I happen to disagree strongly with this view but it's a responsibly presented view. There is also the increasingly stated view from the new left that population control is simply a capitalist device to further subjugate the black and brown people by practicing a subtle form of genocide. I don't take this too seriously but it's said so often that somebody needs to say something in response to it.

DR. SANDMIRE:

Yes, I think the people who have worked with the black women who need birth control find that they do not share the view of their leaders. The black political leaders - and politics is politics - whether it be black politics or white politics, or brown politics, or what have you. I think it will always be this way, but on the individual patient level she desires birth control whether she be black, red, white, or yellow. The leaders, in order to compete for the following of their people, will raise the issue of genocide. Are there other questions?

JOHN VAN MILLER (UWGB Student):

I have become interested in the problems associated with birth control pills, and I am wondering, do the problems that have been brought up in the news quite consistently nowadays with the pill, and also with such things as IUD's, seem to have any effect on the people who should be using them?

DR. SANDMIRE:

Maybe we can have Dr. Davis respond first. He did somewhat answer in talking about discontinuation rates and then initially the ninety-five percent acceptor rate, indicating initially his patients were not frightened, but let us have additional comments from Dr. Davis. Or, did I misunderstand your question?

MR. VAN MILLER:

Well, what I would really like to get is kind of a cross section. I am assuming that I am going to get an answer from Dr. Davis that there is not a problem, but maybe from Dr. Green or someone else that I will get another response.

DR. SANDMIRE:

Well, I am anxious to hear what Dr. Davis will say.

DR. DAVIS:

Certainly there is a problem. But it should be borne in mind that what goes on in the press media affects the middle class and gets them more excited than it does the people at the bottom of the socio-economic heap. The further down you get on the socio-economic scale, the less you watch the news. It is pretty dull anyhow, and you are less concerned about the ups and downs of the stock market, and you don't follow all the controversies about food and drugs and mercury in swordfish. In fact, there are more women on oral contraception in this country today than there were a year ago when these questions were raised. The drug companies are not all dying as they claimed to be in the early spring. Their stocks have gone up and their sales are marching along very well. A positive result of discussing pill related problems is that most women have switched to lower doses of the pill. The improved pills are creating less problems, less side reactions, and less complications. Another positive result has been the development and application of better methods. For example, the intrauterine devices that we were using ten years ago were not good and they did come out quite frequently and they did produce a lot of problems. The ones we have today are not perfect but they are close to it.

DR. GREEN:

I, of course, don't have even remotely the experience that Dr. Davis does, but I can say from the very limited experience that I have (again I must stress as an internist and not as a gynecologist so I am totally unfamiliar with IUD insertions) that patients to whom I give birth control pills do raise questions. But I think that most of them accept them, that most of them come because they want them, or they want some form of contraception. I do feel very strongly that it is not for me to tell them what kind of contraceptive they should use. If they have a specific medical contraindication to one agent such as a previous thrombosis, I would urge them, in fact I would insist that they not use birth control pills. But I am sure acceptance depends on how much time you spend with the patient, and in Dr. Davis' case he seems to have a most excellent program with his registered nurse, and I am sure that she has allayed the fears of the people who come to her. But, of course, I see very few people for this really. I have not noticed any major problems in the patients for whom I have prescribed.

DR. SANDMIRE:

Miss Draper - this is Miss Draper from The Population Institute in Washington, D.C.

JOAN DRAPER (The Population Institute):

Thank you. I am glad you called on me because I have two questions. One to Evelyn Farrell and one to Dr. Sager.

I run a student project and I am concerned with what you think is going on. A year ago in Science, there was an editorial discussing a survey that was taken at Cornell where sixty-five percent of the people surveyed admitted "yes, there is a population problem", but still said they wanted three or four children. My question is, do you see that attitude prevalent among students at UWGB and the UWGB student is invited to respond also. And what - how is it possible to begin to generate a feeling of individual responsibility concerning population growth in this country and limitation of family size. And then I will wait on the second question.

DR. SANDMIRE:

Mrs. Farrell, do you want to respond first.

EVELYN FARRELL:

The girls I have talked to in school here have either said they they are going to wait and get married later on, or they might not get married at all, or if they do get married they might not have any children. That's a lot different from when I was in school because when I was in school that was the thing to do - get married, have kids, and stay home. I do think it's been changing. When it comes to abortion, they don't know. But I don't think they would stop someone from having an abortion. They think it's up to each person individually, it's not that the Catholics should say no one can have an abortion. If they don't want to, they won't.

DR. SANDMIRE:

Then you are saying that in your experience with students, it is different from the survey of the Cornell students.

EVELYN FARRELL:

Yes, and when we did this symposium last year, we took a survey of the community. That was really shocking because this community is very, very conservative.

DR. SANDMIRE:

What were the findings in that survey?

EVELYN FARRELL:

A lot of them didn't even know there was a population problem, and if they did know, it happened in India not in Wisconsin. When you say what about the pollution, they say well that has nothing to do with people; that's just the factories who are dumping their wastes into the waters. And even the social workers surprised me because they should be dealing with welfare people who have children - that they know that they keep having children but they didn't think there was a population problem either.

DR. SANDMIRE:

Now, this question she raises is important and Dr. Pohlman alluded to it also and the people who are here are obviously here for a reason - mostly because they are concerned. What she is saying is that an educational effort is required and I would believe that because of UWGB and the impact that the institution has on the community that even now only one year later, her survey may be returned with a finding that would be different than a year ago. Dr. Sager, would you like to comment?

DR. SAGER:

I think that it has all been said. As far as educational awareness - I am not sure how much this is going to help to change at least older people's attitudes and I am not sure what the answer is to that.

MARY VAN MILLER (UWGB Student):

I just wanted to make a comment as far as the students at UWGB. A faculty member I know took a survey in one of his large lecture classes and this was last spring, if I recall; it might have been in the fall, but I am almost sure that it was in the spring, and I was shocked to find out that the average number of children that the students wanted was three point something, so that it ranged higher than two, which, you know, we like to think is what the students of UWGB, being educated, would want. And it did run as high - some of the kids wanted seven children. I have a friend personally who, and we have talked to her, and she has heard Paul Ehrlich and everything, but she can understand it, she agrees, but she still wants more than two children, and I wouldn't say that the students at UWGB are necessarily educated and we are going to have less children because we have attended this institution.

DR. SANDMIRE:

Dr. Green, do you have a comment.

DR. GREEN:

Talking about surveys, I would just like to quote one survey - I am not exactly sure of the figures - but in the J.A.M.A. recently there was a survey of, I think, fifty married students, half couples. Half were married medical students and half were married non-medical students. The first part of the question was what they considered the ideal number of children to be. I am not exactly sure of the percentage, but almost universally both groups - both the married medical students and the married non-medical students, said two to three. The second part of the question was how many children do each couple plan to have, and almost universally the married non-medical students said two to three, or less than three. But the majority of the married medical students said four or more. The point of this was that when the economic factor was raised and in terms of projected income, you then had the selfish attitude appearing where the medical students projected their eventual income and the ability to educate their children, even though they agreed that ideally the family should be between two and three children - I want to say again that I am not exactly sure of the figures - but certainly more than fifty percent were going to have more than three children.

BOB LOPEZ:

I would like to comment a little bit about the students' feelings towards the number of children and this sort of thing because ZPG has conducted sort of a survey on this. It seems that in the younger students at the University, where they are being hit more in the LES, both in the freshman and sophomore level, there is a greater awareness of the population problem. However, this doesn't universally mean that they want fewer children but there is a much greater awareness. However, at the older levels there is still quite a bit of opposition, even though they are students here.

STAN STEFFEK (Student, Southwest High School):

What I want to say is directed to Dr. Davis. You said something about businessmen in blue tinted windows looking down and saying "all the stupid natives" and I guess you seemed to disagree with that. I would like to say that the natives are stupid with the reservation that if this is wrong, they are backwards. What I mean is not necessarily dealing with population, but with the whole environment totally. Like, why the President wants the SST which is a total environment destroyer, and things like this; and dealing with the attitude of people - when I said they were backward like - this deals with my parents and it's not meant to be a crack at them - but my parents, you know they know that I am against pollution and that, and a lot of times I get home and they think I am trying to solve pollution completely which cannot be done because by surviving you pollute. And I think the people don't realize that we cannot stop, we are just trying to minimize, and it's the attitude that has to be changed, and this.

DR. SANDMIRE:

That's sort of a general question Dr. Davis. Can you respond?

DR. DAVIS:

It's very interesting to see how easily we slide psychologically into an acceptance of a concept without examining it. Perhaps Dr. Pohlman will challenge me on this point, but I doubt that the opinions as to ideal family size of the students currently at Cornell University will prove to be a valid means of predicting their behavior in the future.

Certainly, attitudes do influence what people do. But in the last analysis, when a woman has a child this changes her attitude and it changes the attitudes of her husband; attitudes change again when a second child arrives. This is a dynamic process and people do not sit down and calculate the economic advantages and disadvantages over a twenty-five year period when they go to bed on Saturday night. They have their minds on other matters. We must supply them with effective means of limiting family size without frustrating sexual expression, rather than sit on our hands because of opinion surveys.

MRS. BETTY BROWN (UWGB):

This one is for Dr. Sager, or anybody else who wants to respond. I wonder if any studies or thought has been given - I am sure some thought has been given to it - but do we have any studies about what's happened in the total family dynamics of some of the women who have in a very real sense been relieved of dependency by their ability to end fertility?

DR. SAGER:

Perhaps Dr. Pohlman would like to comment.

DR. POHLMAN:

I don't know the literature on that particular subquestion. I know that there has been speculation on this. That it - both in cause and effect - there has been speculation that having smaller families will now have the effect of changing women's roles and putting the causation the other way, that if you change women's roles they will want smaller families. The research is kind of mushy and hard to do. The Westoff-Princeton studies - I don't know whether that rings a bell with you - tried to tie in the role of women and family size but not to trace out the causal sequence in the way that you are implying. I don't really feel very qualified to answer the question.

KAREN LEPIANKA (UWGB Student):

My question is addressed to Dr. Pohlman or Dr. Davis. In both of your speeches you mentioned the factor of incentives in family planning. I wrote to Mr. Byrnes in Washington and asked the following question (which he didn't answer): "Why isn't there an incentive program in which money is allotted to couples not to have their first child"? In your speeches you did mention incentives, but not the dangers or reasons why we are not using them already in the United States.

DR. POHLMAN:

At the risk of trying to sell my own books, I would say that the only full length monograph that has ever been written on incentives in population control, is the one to which I referred previously which is now in press in Chapel Hill, North Carolina, as part of the Carolina Population Center Monograph Series. We have tried to look very comprehensively at all of the different programs of incentives that have been tried out and most of the ones that have been suggested - at least at the major types in various parts of the world. So that we do give particular attention to your question, as I understand the question.

Now, Raven Hoak, the head of A.I.D. Family Planning Programs, suggested in the spring of 1967, that it would be very desirable in many of the developing countries of the world, he thought, to try out a program where you tried to postpone the arrival of the first child by incentives to young ladies. This gets into the question of whether it is desirable to postpone the first birth. Your neighbor over here in Madison, Dr. Norman Ryder, noted demographer there, has, in the 1970 American Sociological Convention in Chicago, spelled out about fourteen reasons why he thought it to be advantageous to delay the birth of the first baby.

And I happen to agree on most of these points. Economically, I think we have little research to show that you are better off financially if you delay the arrival of the first youngster. I think in many cases a plot of the results would give a U-shaped curve; i.e. if you have the first baby too young or too late, the problems increase. I think that all of my Ob-Gyn. friends will attest that this is true to some extent in terms of the survival of the youngster, the still birth rate, and the mother's health. I suspect this is probably true in terms of marriage relations. I think it's probably true in terms of psychological effects on the child and it's true in effects of sterility. So, it depends on how young is young. If you are talking about a delay of marriage into the early 20's, on most of these criteria you are getting into an optimum time. The one exception is that there seems to be a decrease in physiological capacity for a couple, whoever is to blame, for a couple to reproduce children and we don't know exactly when this decrease starts. But it seems to start around age twenty, and I will be glad to have corrections as to the information on this. So that the one thing you run the risk is that if you postpone the birth of the first baby until twenty-five, there may be a slight increase in the chance that you might not be able to conceive your own youngster. Of course, you can say you will just adopt. But others would feel that you are tricking people if you say - you know - "have a happy family, enjoy your youth, go to Europe, get a job and get your education, and then have your own child". But then all of a sudden you come along and you can't have children, and you shoot the people from Planned Parenthood because they encouraged you to postpone. I don't know if I am really talking to your question.

KAREN LEPIANKA:

You really did. But I don't understand why we don't have incentive programs for people in the United States right now.

DR. POHLMAN:

What incentives?

KAREN LEPIANKA:

Incentive programs using money is what I am concerned with. Many couples I talk with would be more than happy to get some money for postponing their first baby. I have my first baby now, but it would have been a marvelous incentive for me. Maybe we would have waited longer to have our first child. At least these programs should be available for those who want to use it.

DR. POHLMAN:

You are talking about incentives to postpone first births and that is politically a touchy subject in almost all of the world today, including our own country.

Even though abortion for the unmarried and contraception for the unmarried are touchy matters, they are a lot closer to being realized than paid incentives not to have children. You have a consensus among the liberals that it is good to have premarital contraception for people who are sexually active, though there is not unanimity even among the liberals. But on the question of incentives even the liberals don't agree.

DR. DAVIS:

I would certainly concur in the point that you (Mrs. Lepianka) have expressed and I think the last thing that Dr. Pohlman touched upon really is the nub of the matter. The biggest public health problem in the United States of America today is teenage illegitimate pregnancy. This is far larger than tuberculosis, or cancer, as a social evil. I myself am not at all concerned about the girl either. I'm very concerned about the outcome of that child born into a very unfortunate set of circumstances in the City of Baltimore. Forty percent of the children born during 1969 were illegitimate. The majority of these births were among girls under the age of nineteen. In nearly 2,000 births in the City, the girls were under sixteen - eleven and twelve year old girls who have no provision of contraceptive services. You have a perfectly ridiculous legal situation in Maryland. A fourteen year old girl can get pregnant, can come to the hospital, and say "I am pregnant, I am very emotionally distressed, and I need to have it terminated so that I can finish my school; I got caught and it's terrible". And she can sign her name, get the proper work up, and get a therapeutic abortion on her own signature. She can turn around and come back six weeks later and say "Now I want some birth control because I don't want to get into this trap again". Trap is the right word because from a perfectly legal point of view, I cannot give this girl birth control without having her mother and father come in and sign a long, legal document. Well now, this is absurd. Sexual activity is a reality which we must recognize. What we have the power to do is prevent illegitimate pregnancy by removing the legal and administrative restrictions on the provision of services.

Planned Parenthood is frightened by these laws and physicians have to recognize in private practice that they could be confronted by some angry six foot parent saying: "What are you doing giving my daughter birth control?" Of course, what you are doing is preventing teenage illegitimate pregnancies, and legal sanction must be given to this pressing public health need.

DR. CROW:

I want to ask a question of Dr. Pohlman. There is a lot of anecdotal talk among the Japanese that social pressure is an important factor in lowering the Japanese birth rate. The story has been told about a professor who was teaching in this country and was offered a position in Japan that he would really have liked to take, but he didn't want to go back because he had four children and he thought he would be subject to social ridicule. I don't know whether studies have been done following up on such anecdotal information or not.

DR. POHLMAN:

It's pretty hard to research whether social pressure is indeed effective. Many psychologists are comfortable in the laboratory, and so there are studies of this kind now going on in which they pull a group of students or married couples - or both - into a socio-psychological laboratory situation. And they set up some sort of a deal where maybe they have some stooges there to start the group pressure in one direction. And then after a discussion, they ask the people "Now how many do you think you would like to have". And they try to see whether social pressure in the experimental laboratory is effective. And I suppose that's relevant to your concern, but, of course, we are always worried - all of us - about the application of these experimental laboratory situations to the field setting. I do think we are going on faith instead of research - I do think that social pressure is extremely important.

I would like to comment on Dr. Davis' twice-made statement about the couple on Saturday night and what they think of. If you follow his implied reasoning, as I understand it, perhaps distorting it to its logical conclusion, this means that every couple in every part of the United States, and in every part of the world, granted that they have the same availability of contraceptive methods, would have the same family size. And I don't believe that. So, I think that there are some factors other than this marvelous work that he is doing, which I am very much impressed with, to make good birth control methods available. Still, if you look at things from different religious groups, different social class groups, different cultures in the world, I feel pretty confident that even if you have contraceptive availability one hundred percent controlled, you would still get very substantial differences in family size. And so, couples do think of something on Saturday night - or at least the week before when they go to see Herb, or sometime along the way.

SANDI BAKER (Student, Preble High School):

I would like to address this to anyone who has an opinion, or to you Dr. Sandmire,as President of ZPG. Last summer when I and a friend went to some county fairs to run a booth for ZPG, we went with my brother, and the people there - a lot were farm people - they kind of look at you from the corner of their eye and try and ignore you - or they look at you like you are some sort of radical person. And, these symposiums and ZPG reach mostly people who are already aware of the problem. What can be done, or what is being done, about the people who already have opinions formed, or who look at you as radicals.

DR. SANDMIRE:

First of all Sandi, we have to recognize that none of us were too bright a few years ago. All you have to do is to ask the age of our youngest child and that is the quickest way to put me in my place. Even though, and Dr. Pohlman referred to this too, changing of attitudes and education is a slow process, a symposium like this has an impact by way of television, newspaper coverage, etc. far greater than the impact on the attending person. So I would respond that I am not as pessismistic as you are. I think your point is well taken, but I would say don't be discouraged, things take time and I am hopefully optimistic that reasonable people will react to information intelligently presented as those persons do who indicate their concern by attending this symposium.

ERNEST COONEY (Wisconsin Division of Health):

In partial comment on that and also a question. I am working with a group now in a rural small town Wisconsin area, in which there is a quasi-coalition - strange bedfellow if you will - of ZPG groups and the Jaycettes which are somewhat dissimilar as you know. The Jaycettes as a whole have on the average of four to five children; the ZPG people are mostly in college at the present time - some have children and some don't; most have one child if they have a child. I am very concerned about the rate of change and I am wondering, I think Dr. Davis and Dr. Pohlman could most significantly go into this, after hospital programs are started, what do you see as effective change factors in getting other hospitals in the area to start, getting other groups to get involved, and accelerate the process that cannot be short circuited, but only hopefully accelerated.

DR. SANDMIRE:

Dr. Davis, let's have your response first.

DR. DAVIS:

I think you are referring to eddy effects, and I think that's one of the purposes of a gathering of this kind. It's true that we seem to be all talking to each other and everybody was in agreement to begin with before they ever got here, except for some minor quarrels about what priorities should be. Certainly none of us favor a continued lack of service or continued lack of adequate research to find out about motivational factors or any of the things involved in controlling population crises. There is no question but what the intercommunication that occurs here, however, stimulates increased action. I suspect there are physicians who have been here at this conference who will perhaps go home and feel more comfortable about some things they have been doing to meet the needs of their community.

The debate that has taken place here today is very similar to discussions in my state five and ten years ago. The State Health Department was slow to move in this direction; they were afraid of being criticized.

We were fortunate in being a private hospital. We started sending residents out to some of the county clinics and providing services in that way. Once it was apparent the clinics were working and nobody was protesting, the State got brave and started having a program of their own, and now they have an excellent program operating. All of this takes time, and the process starts a little later in some places than in others. There is also a time course of opinion change within the medical profession as well as within the political thinking of the community. All this has to go on as a time process and sometimes one segment gets a little ahead of the other. But you just will not be able to alter everything in one year. I certainly would agree with Dr. Pohlman in that regard, no matter what the incentives are.

DR. SANDMIRE:

Then, I have to say that our time is up and if any of the panel members wish to make a brief comment or statement that they feel the information is important, but have not been asked.

DR. POHLMAN:

Well, I would like to say again very emphatically how much I have enjoyed being here these last couple of days and how much admiration I have for the personnel who put together this series of symposia, and I appreciate it very much.

DR. DAVIS:

I would like to echo Dr. Pohlman's sentiments and I would also like to tell you something I learned here: I found out how to deal with the woman who says that she wants ten children. You deal with this by copying the methods of Alcoholics Anonymous - you send her around for a chat with a woman who already has ten children. I pass that on to you.

DR. SANDMIRE:

Dr. Taylor will close the symposium.

DR. TAYLOR:

Ladies and gentlemen - Dr. Pohlman and Dr. Davis have to leave. Before they get out the door, I wish to extend our thanks to both of them for talks which were noteworthy for their lacing of humor. Thank you very much.

After that - I think it has already been said once, but it's a hard act to follow, but it is my privilege to make some concluding remarks. They will be brief. I find that in the last day and one-half I have alternated between hope and despair. Although attempts at solutions of the population problems got off to a very late start, the most striking thing to me is the fantastic present rate of change on a number of fronts: in techniques, in the laws, in services available, in public attitudes. There seems to have been a consensus, if not a unanimity, in two areas - so much so that they were hardly even mentioned. One: the idea is that sex is dirty and sinful seems to be passe - certainly in this group. The other idea which seems to be universally accepted in this group is that the marriage institution is changing and will probably continue to change. I think we should not lose sight, as has been mentioned at least once this morning, that this is a select and probably not a representative group. There are large gaps in our knowledge - this has come out repeatedly - where we just do not know what the answers are with the commensurate opportunities, or demand, if you wish, for research.

I was most impressed by one comment - or one series of comments - that was made about the changed attitudes of abortion. It was stated that prior to the eighteenth century abortion was a woman's right provided that it was asked for before she felt life. Abortion was later abandoned, or outlawed, or made illegal for valid medical reasons. The abortion itself was a dangerous operation and to justify it, the risks of carrying on the pregnancy had to be at least as great as, if not greater than, the risk of abortion. Today's public attitudes have almost completely lost sight of this. The reason for denying abortion to a woman has changed completely: it's now a moral problem. I think that there may be a number of things that we regard as moral concepts which have the same sort of background, and I suggest a number of our institutions and attitudes might be examined in this light. I would suggest, for example, the marriage institution itself, legitimacy, free enterprise (to depart a moment from the specific subject), prostitution, standards of living (the idea that certain standards of living are high, and therefore, good), homosexuality, and last but not least, the role of women.

Finally, it is my pleasure to thank all of the speakers, most of them now in absentia, for the contributions they have made. Many of them have been thanked before. I won't name them all because it totals twenty and it would be boring. There is one person, however, whom I do wish to mention by name and he is the prime organizer of the symposium, Dr. Doberenz. He has remained in the background and that's where he is right now, attending to Symposium business. We all owe him thanks for his successful organization of this Symposium.

The symposium is concluded.

GENERAL REFERENCE LIST

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